

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 4003 Shepherd St	
3. NAME OF DECEASED (Type or print) Virginia		4. DATE OF DEATH May 3, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1873
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Stallard		14. MOTHER'S MAIDEN NAME Mary Talbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Worley Adams		18. ADDRESS 4003 Shepherd st Brentwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 12 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1953 to May 3, 1956, that I last saw the deceased alive on May 2, 1956, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leon R. Gallin M.D.		7206 Colesville Road University Heights	
PHYSICIAN'S NAME (Type) LEON R. GALLIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation May 3, 1956		22b. DATE THEREOF Norton	
22c. NAME OF CEMETERY OR CREMATORY Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 5/3/56	
24b. REGISTRAR'S SIGNATURE Winanda L...			

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH A. HOME		HOSPITAL	
B. CITY OR TOWN		C. COUNTY	
D. STATE		E. DISTRICT	
F. ZIP CODE		G. STREET	
H. CITY OR TOWN		I. COUNTY	
J. STATE		K. DISTRICT	
L. ZIP CODE		M. STREET	
N. CITY OR TOWN		O. COUNTY	
P. STATE		Q. DISTRICT	
R. ZIP CODE		S. STREET	
T. CITY OR TOWN		U. COUNTY	
V. STATE		W. DISTRICT	
X. ZIP CODE		Y. STREET	
Z. CITY OR TOWN		AA. COUNTY	
AB. STATE		AC. DISTRICT	
AD. ZIP CODE		AE. STREET	
AF. CITY OR TOWN		AG. COUNTY	
AH. STATE		AI. DISTRICT	
AJ. ZIP CODE		AK. STREET	
AL. CITY OR TOWN		AM. COUNTY	
AN. STATE		AO. DISTRICT	
AP. ZIP CODE		AQ. STREET	
AR. CITY OR TOWN		AS. COUNTY	
AT. STATE		AU. DISTRICT	
AV. ZIP CODE		AW. STREET	
AX. CITY OR TOWN		AY. COUNTY	
AZ. STATE		BA. DISTRICT	
BB. ZIP CODE		BC. STREET	
BD. CITY OR TOWN		BE. COUNTY	
BF. STATE		BG. DISTRICT	
BH. ZIP CODE		BI. STREET	
BJ. CITY OR TOWN		BK. COUNTY	
BL. STATE		BM. DISTRICT	
BN. ZIP CODE		BO. STREET	
BP. CITY OR TOWN		BQ. COUNTY	
BR. STATE		BS. DISTRICT	
BT. ZIP CODE		BU. STREET	
BV. CITY OR TOWN		BW. COUNTY	
BX. STATE		BY. DISTRICT	
BZ. ZIP CODE		CA. STREET	
CB. CITY OR TOWN		CC. COUNTY	
CD. STATE		CE. DISTRICT	
CF. ZIP CODE		CG. STREET	
CH. CITY OR TOWN		CI. COUNTY	
CK. STATE		CL. DISTRICT	
CM. ZIP CODE		CN. STREET	
CO. CITY OR TOWN		CP. COUNTY	
CQ. STATE		CR. DISTRICT	
CS. ZIP CODE		CT. STREET	
CU. CITY OR TOWN		CV. COUNTY	
CW. STATE		CX. DISTRICT	
CY. ZIP CODE		CA. STREET	
CB. CITY OR TOWN		CC. COUNTY	
CD. STATE		CE. DISTRICT	
CE. ZIP CODE		CF. STREET	
CF. CITY OR TOWN		CG. COUNTY	
CG. STATE		CH. DISTRICT	
CH. ZIP CODE		CI. STREET	
CI. CITY OR TOWN		CJ. COUNTY	
CJ. STATE		CK. DISTRICT	
CK. ZIP CODE		CL. STREET	
CL. CITY OR TOWN		CM. COUNTY	
CM. STATE		CN. DISTRICT	
CN. ZIP CODE		CO. STREET	
CO. CITY OR TOWN		CP. COUNTY	
CP. STATE		CQ. DISTRICT	
CQ. ZIP CODE		CR. STREET	
CR. CITY OR TOWN		CS. COUNTY	
CS. STATE		CT. DISTRICT	
CT. ZIP CODE		CU. STREET	
CU. CITY OR TOWN		CV. COUNTY	
CV. STATE		CW. DISTRICT	
CW. ZIP CODE		CX. STREET	
CX. CITY OR TOWN		CY. COUNTY	
CY. STATE		CZ. DISTRICT	
CZ. ZIP CODE		DA. STREET	
DA. CITY OR TOWN		DB. COUNTY	
DB. STATE		DC. DISTRICT	
DC. ZIP CODE		DD. STREET	
DD. CITY OR TOWN		DE. COUNTY	
DE. STATE		DF. DISTRICT	
DF. ZIP CODE		DG. STREET	
DG. CITY OR TOWN		DH. COUNTY	
DH. STATE		DI. DISTRICT	
DI. ZIP CODE		DJ. STREET	
DJ. CITY OR TOWN		DK. COUNTY	
DK. STATE		DL. DISTRICT	
DL. ZIP CODE		DM. STREET	
DM. CITY OR TOWN		DN. COUNTY	
DN. STATE		DO. DISTRICT	
DO. ZIP CODE		DP. STREET	
DP. CITY OR TOWN		DQ. COUNTY	
DQ. STATE		DR. DISTRICT	
DR. ZIP CODE		DS. STREET	
DS. CITY OR TOWN		DT. COUNTY	
DT. STATE		DU. DISTRICT	
DU. ZIP CODE		DV. STREET	
DV. CITY OR TOWN		DW. COUNTY	
DW. STATE		DX. DISTRICT	
DX. ZIP CODE		DY. STREET	
DY. CITY OR TOWN		DZ. COUNTY	
DZ. STATE		EA. DISTRICT	
EA. ZIP CODE		EB. STREET	
EB. CITY OR TOWN		EC. COUNTY	
EC. STATE		ED. DISTRICT	
ED. ZIP CODE		EE. STREET	
EE. CITY OR TOWN		EF. COUNTY	
EF. STATE		EG. DISTRICT	
EG. ZIP CODE		EH. STREET	
EH. CITY OR TOWN		EI. COUNTY	
EI. STATE		EJ. DISTRICT	
EJ. ZIP CODE		EK. STREET	
EK. CITY OR TOWN		EL. COUNTY	
EL. STATE		EM. DISTRICT	
EM. ZIP CODE		EN. STREET	
EN. CITY OR TOWN		EO. COUNTY	
EO. STATE		EP. DISTRICT	
EP. ZIP CODE		EQ. STREET	
EQ. CITY OR TOWN		ER. COUNTY	
ER. STATE		ES. DISTRICT	
ES. ZIP CODE		ET. STREET	
ET. CITY OR TOWN		EU. COUNTY	
EU. STATE		EV. DISTRICT	
EV. ZIP CODE		EW. STREET	
EW. CITY OR TOWN		EX. COUNTY	
EX. STATE		EY. DISTRICT	
EY. ZIP CODE		EZ. STREET	
EZ. CITY OR TOWN		FA. COUNTY	
FA. STATE		FB. DISTRICT	
FB. ZIP CODE		FC. STREET	
FC. CITY OR TOWN		FD. COUNTY	
FD. STATE		FE. DISTRICT	
FE. ZIP CODE		FF. STREET	
FF. CITY OR TOWN		FG. COUNTY	
FG. STATE		FH. DISTRICT	
FH. ZIP CODE		FI. STREET	
FI. CITY OR TOWN		FJ. COUNTY	
FJ. STATE		FK. DISTRICT	
FK. ZIP CODE		FL. STREET	
FL. CITY OR TOWN		FM. COUNTY	
FM. STATE		FN. DISTRICT	
FN. ZIP CODE		FO. STREET	
FO. CITY OR TOWN		FP. COUNTY	
FP. STATE		FQ. DISTRICT	
FQ. ZIP CODE		FR. STREET	
FR. CITY OR TOWN		FS. COUNTY	
FS. STATE		FT. DISTRICT	
FT. ZIP CODE		FU. STREET	
FU. CITY OR TOWN		FV. COUNTY	
FV. STATE		FW. DISTRICT	
FW. ZIP CODE		FX. STREET	
FX. CITY OR TOWN		FY. COUNTY	
FY. STATE		FZ. DISTRICT	
FZ. ZIP CODE		GA. STREET	
GA. CITY OR TOWN		GB. COUNTY	
GB. STATE		GC. DISTRICT	
GC. ZIP CODE		GD. STREET	
GD. CITY OR TOWN		GE. COUNTY	
GE. STATE		GF. DISTRICT	
GF. ZIP CODE		GG. STREET	
GG. CITY OR TOWN		GH. COUNTY	
GH. STATE		GI. DISTRICT	
GI. ZIP CODE		GJ. STREET	
GJ. CITY OR TOWN		GK. COUNTY	
GK. STATE		GL. DISTRICT	
GL. ZIP CODE		GM. STREET	
GM. CITY OR TOWN		GN. COUNTY	
GN. STATE		GO. DISTRICT	
GO. ZIP CODE		GP. STREET	
GP. CITY OR TOWN		GQ. COUNTY	
GQ. STATE		GR. DISTRICT	
GR. ZIP CODE		GS. STREET	
GS. CITY OR TOWN		GT. COUNTY	
GT. STATE		GU. DISTRICT	
GU. ZIP CODE		GV. STREET	
GV. CITY OR TOWN		GW. COUNTY	
GW. STATE		GX. DISTRICT	
GX. ZIP CODE		GY. STREET	
GY. CITY OR TOWN		GZ. COUNTY	
GZ. STATE		HA. DISTRICT	
HA. ZIP CODE		HB. STREET	
HB. CITY OR TOWN		HC. COUNTY	
HC. STATE		HD. DISTRICT	
HD. ZIP CODE		HE. STREET	
HE. CITY OR TOWN		HF. COUNTY	
HF. STATE		HG. DISTRICT	
HG. ZIP CODE		HH. STREET	
HH. CITY OR TOWN		HI. COUNTY	
HI. STATE		HJ. DISTRICT	
HJ. ZIP CODE		HK. STREET	
HK. CITY OR TOWN		HL. COUNTY	
HL. STATE		HM. DISTRICT	
HM. ZIP CODE		HN. STREET	
HN. CITY OR TOWN		HO. COUNTY	
HO. STATE		HP. DISTRICT	
HP. ZIP CODE		HQ. STREET	
HQ. CITY OR TOWN		HR. COUNTY	
HR. STATE		HS. DISTRICT	
HS. ZIP CODE		HT. STREET	
HT. CITY OR TOWN		HU. COUNTY	
HU. STATE		HV. DISTRICT	
HV. ZIP CODE		HW. STREET	
HW. CITY OR TOWN		HX. COUNTY	
HX. STATE		HY. DISTRICT	
HY. ZIP CODE		HZ. STREET	
HZ. CITY OR TOWN		IA. COUNTY	
IA. STATE		IB. DISTRICT	
IB. ZIP CODE		IC. STREET	
IC. CITY OR TOWN		ID. COUNTY	
ID. STATE		IE. DISTRICT	
IE. ZIP CODE		IF. STREET	
IF. CITY OR TOWN		IG. COUNTY	
IG. STATE		IH. DISTRICT	
IH. ZIP CODE		II. STREET	
II. CITY OR TOWN		IJ. COUNTY	
IJ. STATE		IK. DISTRICT	
IK. ZIP CODE		IL. STREET	
IL. CITY OR TOWN		IM. COUNTY	
IM. STATE		IN. DISTRICT	
IN. ZIP CODE		IO. STREET	
IO. CITY OR TOWN		IP. COUNTY	
IP. STATE		IQ. DISTRICT	
IQ. ZIP CODE		IR. STREET	
IR. CITY OR TOWN		IS. COUNTY	
IS. STATE		IT. DISTRICT	
IT. ZIP CODE		IU. STREET	
IU. CITY OR TOWN		IV. COUNTY	
IV. STATE		IW. DISTRICT	
IW. ZIP CODE		IX. STREET	
IX. CITY OR TOWN		IY. COUNTY	
IY. STATE		IZ. DISTRICT	
IZ. ZIP CODE		JA. STREET	
JA. CITY OR TOWN		JB. COUNTY	
JB. STATE		JC. DISTRICT	
JC. ZIP CODE		JD. STREET	
JD. CITY OR TOWN		JE. COUNTY	
JE. STATE		JF. DISTRICT	
JF. ZIP CODE		JG. STREET	
JG. CITY OR TOWN		JH. COUNTY	
JH. STATE		JI. DISTRICT	
JI. ZIP CODE		JJ. STREET	
JJ. CITY OR TOWN		JK. COUNTY	
JK. STATE		JL. DISTRICT	
JL. ZIP CODE		JM. STREET	
JM. CITY OR TOWN		JN. COUNTY	
JN. STATE		JO. DISTRICT	
JO. ZIP CODE		JP. STREET	
JP. CITY OR TOWN		JQ. COUNTY	
JQ. STATE		JR. DISTRICT	
JR. ZIP CODE		JS. STREET	
JS. CITY OR TOWN		JT. COUNTY	
JT. STATE		JU. DISTRICT	
JU. ZIP CODE		JV. STREET	
JV. CITY OR TOWN		JW. COUNTY	
JW. STATE		JX. DISTRICT	
JX. ZIP CODE		JY. STREET	
JY. CITY OR TOWN		JZ. COUNTY	
JZ. STATE		KA. DISTRICT	
KA. ZIP CODE		KB. STREET	
KB. CITY OR TOWN		KC. COUNTY	
KC. STATE		KD. DISTRICT	
KD. ZIP CODE		KE. STREET	
KE. CITY OR TOWN		KF. COUNTY	
KF. STATE		KG. DISTRICT	
KG. ZIP CODE		KH. STREET	
KH. CITY OR TOWN		KI. COUNTY	
KI. STATE		KJ. DISTRICT	
KJ. ZIP CODE		KK. STREET	
KK. CITY OR TOWN		KL. COUNTY	
KL. STATE		KM. DISTRICT	
KM. ZIP CODE		KN. STREET	
KN. CITY OR TOWN		KO. COUNTY	
KO. STATE		KP. DISTRICT	
KP. ZIP CODE		KQ. STREET	
KQ. CITY OR TOWN		KR. COUNTY	
KR. STATE		KS. DISTRICT	
KS. ZIP CODE		KT. STREET	
KT. CITY OR TOWN		KU. COUNTY	
KU. STATE		KV. DISTRICT	
KV. ZIP CODE		KW. STREET	
KW. CITY OR TOWN		KX. COUNTY	
KX. STATE		KY. DISTRICT	
KY. ZIP CODE		KZ. STREET	
KZ. CITY OR TOWN		LA. COUNTY	
LA. STATE		LB. DISTRICT	
LB. ZIP CODE		LC. STREET	
LC. CITY OR TOWN		LD. COUNTY	
LD. STATE		LE. DISTRICT	
LE. ZIP CODE		LF. STREET	
LF. CITY OR TOWN		LG. COUNTY	
LG. STATE		LH. DISTRICT	
LH. ZIP CODE		LI. STREET	
LI. CITY OR TOWN		LJ. COUNTY	
LJ. STATE		LK. DISTRICT	
LK. ZIP CODE		LL. STREET	
LL. CITY OR TOWN		LM. COUNTY	
LM. STATE		LN. DISTRICT	
LN. ZIP CODE		LO. STREET	
LO. CITY OR TOWN		LP. COUNTY	
LP. STATE		LQ. DISTRICT	
LQ. ZIP CODE		LR. STREET	
LR. CITY OR TOWN		LS. COUNTY	
LS. STATE		LT. DISTRICT	
LT. ZIP CODE		LU. STREET	
LU. CITY OR TOWN		LV. COUNTY	
LV. STATE		LW. DISTRICT	
LW. ZIP CODE		LX. STREET	
LX. CITY OR TOWN		LY. COUNTY	
LY. STATE		LZ. DISTRICT	
LZ. ZIP CODE		MA. STREET	
MA. CITY OR TOWN		MB. COUNTY	
MB. STATE		MC. DISTRICT	
MC. ZIP CODE		MD. STREET	
MD. CITY OR TOWN		ME. COUNTY	
ME. STATE		MF. DISTRICT	
MF. ZIP CODE		MG. STREET	
MG. CITY OR TOWN		MH. COUNTY	
MH. STATE		MI. DISTRICT	
MI. ZIP CODE		MJ. STREET	
MJ. CITY OR TOWN		MK. COUNTY	
MK. STATE		ML. DISTRICT	
ML. ZIP CODE		MN. STREET	
MN. CITY OR TOWN		MO. COUNTY	
MO. STATE		MP. DISTRICT	
MP. ZIP CODE		MQ. STREET	
MQ. CITY OR TOWN		MR. COUNTY	
MR. STATE		MS. DISTRICT	
MS. ZIP CODE		MT. STREET	
MT. CITY OR TOWN		MU. COUNTY	
MU. STATE		MV. DISTRICT	
MV. ZIP CODE		MW. STREET	
MW. CITY OR TOWN		MX. COUNTY	
MX. STATE		MY. DISTRICT	
MY. ZIP CODE		MZ. STREET	
MZ. CITY OR TOWN		NA. COUNTY	
NA. STATE		NB. DISTRICT	
NB. ZIP CODE		NC. STREET	
NC. CITY OR TOWN		ND. COUNTY	
ND. STATE		NE. DISTRICT	
NE. ZIP CODE		NF. STREET	
NF. CITY OR TOWN		NG. COUNTY	
NG. STATE		NH. DISTRICT	
NH. ZIP CODE		NI. STREET	
NI. CITY OR TOWN		NJ. COUNTY	
NJ. STATE		NK. DISTRICT	
NK. ZIP CODE		NL. STREET	
NL. CITY OR TOWN		NM. COUNTY	
NM. STATE		NO. DISTRICT	
NO. ZIP CODE		NP. STREET	
NP. CITY OR TOWN		NQ. COUNTY	
NQ. STATE		NR. DISTRICT	
NR. ZIP CODE		NS. STREET	
NS. CITY OR TOWN		NT. COUNTY	
NT. STATE		NU. DISTRICT	
NU. ZIP CODE		NV. STREET	
NV. CITY OR TOWN		NW. COUNTY	
NW. STATE		NX. DISTRICT	
NX. ZIP CODE		NY. STREET	
NY. CITY OR TOWN		NZ. COUNTY	
NZ. STATE		OA. DISTRICT	
OA. ZIP CODE		OB. STREET	
OB. CITY OR TOWN		OC. COUNTY	
OC. STATE		OD. DISTRICT	
OD. ZIP CODE		OE. STREET	
OE. CITY OR TOWN		OF. COUNTY	
OF. STATE		OG. DISTRICT	
OG. ZIP CODE		OH. STREET	
OH. CITY OR TOWN		OI. COUNTY	
OI. STATE		OJ. DISTRICT	
OJ. ZIP CODE		OK. STREET	
OK. CITY OR TOWN		OL. COUNTY	
OL. STATE		OM. DISTRICT	
OM. ZIP CODE		ON. STREET	

TO DEPENDENT: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06406

5385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2424 Lake Avenue		d. STREET ADDRESS 2424 Lake Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Magdurich Arakelian		4. DATE OF DEATH May 27 1956	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1907	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Photograph	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Magdurich Arakelian		14. MOTHER'S MAIDEN NAME Akabie Arakelian (not related)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Anna Arakelian, Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute congestive heart failure DUE TO (b) Hypertensive heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Essential hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 27, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

DATE

8 1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 8 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05364

5386

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton Md.</u>		c. LENGTH OF STAY IN TB <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>109-2nd St.</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence BASEMAN (Beesman)</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General construction, Sykesville, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Fletcher Baseman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ridgely Stanfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>211-12-0901</u>	
17. INFORMANT <u>Clarence Baseman</u>		Address <u>Laurel, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526X</u> DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Congestion & Edema</u> DUE TO <u>1 wk</u> (c) <u>Bronchobasis, chronic</u> DUE TO <u>1 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1956</u> to <u>May 17, 1956</u> that I last saw the deceased alive on <u>May 17, 1956</u> and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.		DATE SIGNED <u>5/18/56</u>	
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u>		ADDRESS (Street, city or town, state) <u>ret/amer, md</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Abington Natl Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Abington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bert H. Henshaw</u>		ADDRESS <u>Laurel, Md.</u>	
24a. REC'D BY REGISTRAR <u>5/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda J. Jernigan</u>	

BUREAU V. S.

1956 72 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5434

CERTIFICATE OF DEATH

05365

Reg. Dist. No. 232

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leeland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leeland	
c. LENGTH OF STAY IN 1b 23 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sophie Middle Klager Last Beall		4. DATE OF DEATH Month May Day 2 Year 19 56.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1878
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Klager		14. MOTHER'S MAIDEN NAME Louise Reichert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Otho T. Beall, Jr.		Address Leeland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956, to 2 May 1956, that I last saw the deceased alive on 2 May 56, 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Sasscer		DATE SIGNED 31 May 57	
PHYSICIAN'S NAME (Type) Robert B. Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/56	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Leeland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE 5/3/56		24b. REGISTRAR'S SIGNATURE John F. Danner	

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5369

CERTIFICATE OF DEATH

05366

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	c. LENGTH OF STAY IN 1b <u>6 Months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>15-17-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>901 Saint Branch Nursing Home</u>	d. STREET ADDRESS <u>700 Kennebec Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Supie</u> First <u>Beaupre</u> Middle Last		4. DATE OF DEATH <u>May</u> Month <u>2</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Luckenburgh</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Enil Bernard</u>		14. MOTHER'S MAIDEN NAME <u>Eva Teis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>records at Nursing Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Reg. Myocarditis & Hypertension</u> DUE TO (c) <u>1947</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/21</u> , 19 <u>49</u> , to <u>5/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/1</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carver Ave</u> DATE SIGNED <u>5/2/56</u>	
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		<u>Takoma Park</u> <u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. T. Morse</u> ADDRESS <u>254 CHURCH ST NW</u>		24a. REC'D BY REGISTRAR <u>DATE May 3 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severel</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

MAY 4 1956

RECEIVED

TO DECEASED NECESSARY: This certificate should be executed within 24 hours after death. If only a portion of the necessary information is available, the certificate should be marked "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05367 31
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General		e. STREET ADDRESS 502 Chillum Road	
3. NAME OF DECEASED (Type or print) First John William Frederick Bell Middle Bell Last Bell		4. DATE OF DEATH Month May Day 18 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 18, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired actor		10b. KIND OF BUSINESS OR INDUSTRY Entertainment	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Bell		14. MOTHER'S MAIDEN NAME Ione Mohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W.I <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 001-14-1569	
17. INFORMANT Ruth B. Snider- Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of abdomen (a), stating the underlying cause last. (c) 776X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 976X 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound	
20c. TIME OF INJURY Month, Day, Year Hour 5-18- 19 56 a. m. P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hyattsville, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 5-18-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or county) Arlington Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400-Chapin St. N.W.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 5/20/56		24b. REGISTRAR'S SIGNATURE Maranda Dornay	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05368

5388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Dead on arrival			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7905 Marlboro Pike			
3. NAME OF DECEASED (Type or print) First Middle Last Mattie McNeer Bobbitt				4. DATE OF DEATH Month Day Year May 22 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1876	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warder				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John William Nutty				14. MOTHER'S MAIDEN NAME Mary Hillery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mattie Faust, Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 442 x Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22. ACTUAL SIGNATURE James I. Boyd				22b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22c. NAME OF CEMETERY OR CREMATORY Garden Hill				22d. LOCATION (City, town, or county) (State) Suitland Md.			
22e. DATE THEREOF May 25, 1956				22f. REC'D BY REGISTRAR DATE May 23, 1956			
22g. REGISTRAR'S SIGNATURE Edna F. Collins				22h. REGISTRAR'S SIGNATURE Edna F. Collins			
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lees Sons Co. 300 4th St. Baltimore, Md.							

MEDICAL CERTIFICATION

TO DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If only necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 31 1956

RECEIVED

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached and used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12, 14 File 7097 5-21-56 et

05369

5389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY 16	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp		d. STREET ADDRESS 190 - 73rd St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leonard Boertlein		4. DATE OF DEATH May 9 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stained Glass Craftsmen		10b. KIND OF BUSINESS OR INDUSTRY Glass	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Boertlein		14. MOTHER'S MAIDEN NAME ?? Fechter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elizabeth Boertlein		Address 190 - 73rd St Seat Pleasant Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Pulmonary Edema, Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 240 (b) Hypertensive Cardiac Vascular Disease DUE TO (c) Diabetes - Hemiplegia, Left		INTERVAL BETWEEN ONSET AND DEATH 5 ds 10 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1952 to May 9, 1956, that I last saw the deceased alive on May 8, 1956, and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley M.D.		ADDRESS (Street, city or town, state) Hyattsville Md	
DATE SIGNED 5/9/56			
PHYSICIAN'S NAME (Type) Gordon W. Kelley M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-1956	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln		22d. LOCATION (City, town, or county) (State) Colman Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Kim Lee + Sons		ADDRESS Washington D.C.	
24a. REC'D BY REGISTRAR DATE 5/11/56		24b. REGISTRAR'S SIGNATURE Amanda Sourney	

BUREAU V. S.

MAY 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Items 13, 14 Filed 1985-28-56 et

5390

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05370

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>4813 Calvert Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie VIRGINIA Boyers</u>		4. DATE OF DEATH Month Day Year <u>5 - 19 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME Given name unknown: <u>BEALL</u>		14. MOTHER'S MAIDEN NAME <u>Statistic Card</u> Surname: <u>Cord</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EDWARD G BOYERS</u>		Address <u>Adelphia Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Lung</u> <u>170X</u> DUE TO <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 MO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>5-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.L. Etienne</u>		ADDRESS (Street, city or town, state) <u>4713 - Bayview Dr College Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		DATE SIGNED <u>5/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24a. REC'D BY REGISTRAR <u>May 22 1956</u>	
ADDRESS <u>Washington DC</u>		24b. REGISTRAR'S SIGNATURE <u>James D. Smith</u>	
<u>1400 Clinton St NW</u>		<u>Amended</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAMES W. WATKINS		62		M		W		1892		1955		AT HOME		HEART DISEASE	
FATHER'S NAME		MOTHER'S NAME		BIRTHPLACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SPECIAL INSTRUCTIONS	
JAMES W. WATKINS		JANE W. WATKINS		MARYLAND		HIGH SCHOOL		LABORER		MARRIED		METHODIST			
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF MINISTER		NAME OF FUNERAL HOME		NAME OF CEMETERY			
1915		BALTIMORE, MD.		MAY 1, 1955		BALTIMORE, MD.		PASTOR J. W. WATKINS		JAMES W. WATKINS		GREENWOOD CEMETERY			
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF STATE DEPARTMENT OF HEALTH			
		JANE W. WATKINS		JAMES W. WATKINS		JAMES W. WATKINS		JAMES W. WATKINS		JAMES W. WATKINS		JAMES W. WATKINS			

BUREAU V. S.

MAY 24 1955

RECEIVED

1400 6/10/55
JAMES W. WATKINS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05371

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
c. LENGTH OF STAY IN 1b 2 years							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2215 Chapman Road				d. STREET ADDRESS 2215 Chapman Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Louise Last Bright				4. DATE OF DEATH Month May Day 21 Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1952	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 56 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Chester Bright				14. MOTHER'S MAIDEN NAME Virginia L. Cochran Cochran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Mother, Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and Interstitial Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 21, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR May 24 1956 Mrs. Jas. Severe		24b. REGISTRAR'S SIGNATURE Deputy	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt as to the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

129
~~597~~

BUREAU V. S.
MAY 25 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5435

CERTIFICATE OF DEATH

05372

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY Prince George's MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Silver Hill, Md. TOWN Life				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince George's CITY (If outside corporate limits, write RURAL and give nearest town) Silver Hill, Maryland TOWN 4465- St. Barnabas Road S.E.			
3. NAME OF DECEASED (First) (Middle) (Last) CLEMENT H. BROOKE SR.				4. DATE OF DEATH (Month) (Day) (Year) May 17 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 12th 1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Gardener		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clement H. Brooke				14. MOTHER'S MAIDEN NAME Margaret E. Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mary R. Brooke 4465- St. Barnabas RD. S.E.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Myocardial Infarction ANTECEDENT CAUSE(S) DUE TO (B) Atherosclerotic Heart Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on 5/17, 1956, and that death occurred at 11:55 AM from the causes and on the date stated above. SIGNATURE Lawrence Phillips M.D. 4698 Rushie Ave Temple Hill Md. 5/17/56 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 19-56		NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		LOCATION (City, town, or county) (State) Oxon Hill, Maryland.	
24. REC'D BY REGISTRAR DATE May 18-56		REGISTRAR'S SIGNATURE Edward F. Collins		25. FUNERAL DIRECTOR'S SIGNATURE Simmons		ADDRESS 1661- Good Hope Rd S.E. Washington, D. C.	

CERTIFICATE OF DEATH

in 24 hours after death: Page 4
in by the funeral director,
and 2 should be filed

states that the

BUREAU Y. S.

MAY 24 1956

RECEIVED

6434

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>16.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitcheville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Brooks</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Johnson, Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Brooks, Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother - as above</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity (weight 60 gms. length 12 cm.)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>May 27, 1956</u> to <u>May 27, 1956</u> , that I last saw the deceased alive on <u>May 27, 1956</u> , and that death occurred at <u>1:57 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John W. Pulcin</u>	DATE SIGNED <u>5/29/56</u>
ADDRESS (Street, city or town, state) <u>5301 Hamlet St, Hyattsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>John W. Pulcin</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp Chesley Md</u>	22d. LOCATION (City, town, or county) (State) <u>Chesley Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Pulcin</u>		ADDRESS <u>Adm</u>	24a. REC'D BY REGISTRAR DATE <u>6-11-56</u>
		24b. REGISTRAR'S SIGNATURE <u>A. W. Hancock</u>	

PITAL OR ATTENDING physician retained by the hospital. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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1956

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>4205 Eastern Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louise</i> First <i>Veronica</i> Middle <i>Brown</i> Last		4. DATE OF DEATH <i>May 16</i> 1956	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 5, 1897</i>
9. AGE (In years last birthday) <i>38</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cumberland, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>USA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Thomas Steele</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Winkler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>daughter</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Insufficiency</i> <i>199.9</i> DUE TO <i>Collapse of left lung & hyperthorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoid Syndrome & metastases to lung, supra clavicular space, liver.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>10 months</i> <i>20 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition & dehydration</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 10</i> , 1954, to <i>May 16</i> , 1956, that I last saw the deceased alive on <i>May 15</i> , 1956, and that death occurred at <i>12:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dee R. Parkinson</i>		ADDRESS (Street, city or town, state) <i>2901 So Dakota Ave NE Wash DC</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>PARKINSON, DEE R</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-18-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS <i>3821 14th St. NW. Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>5-18-1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. J. S. Derr</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 21 1956

BUREAU V. S.

RECEIVED

5436

CERTIFICATE OF DEATH

05374

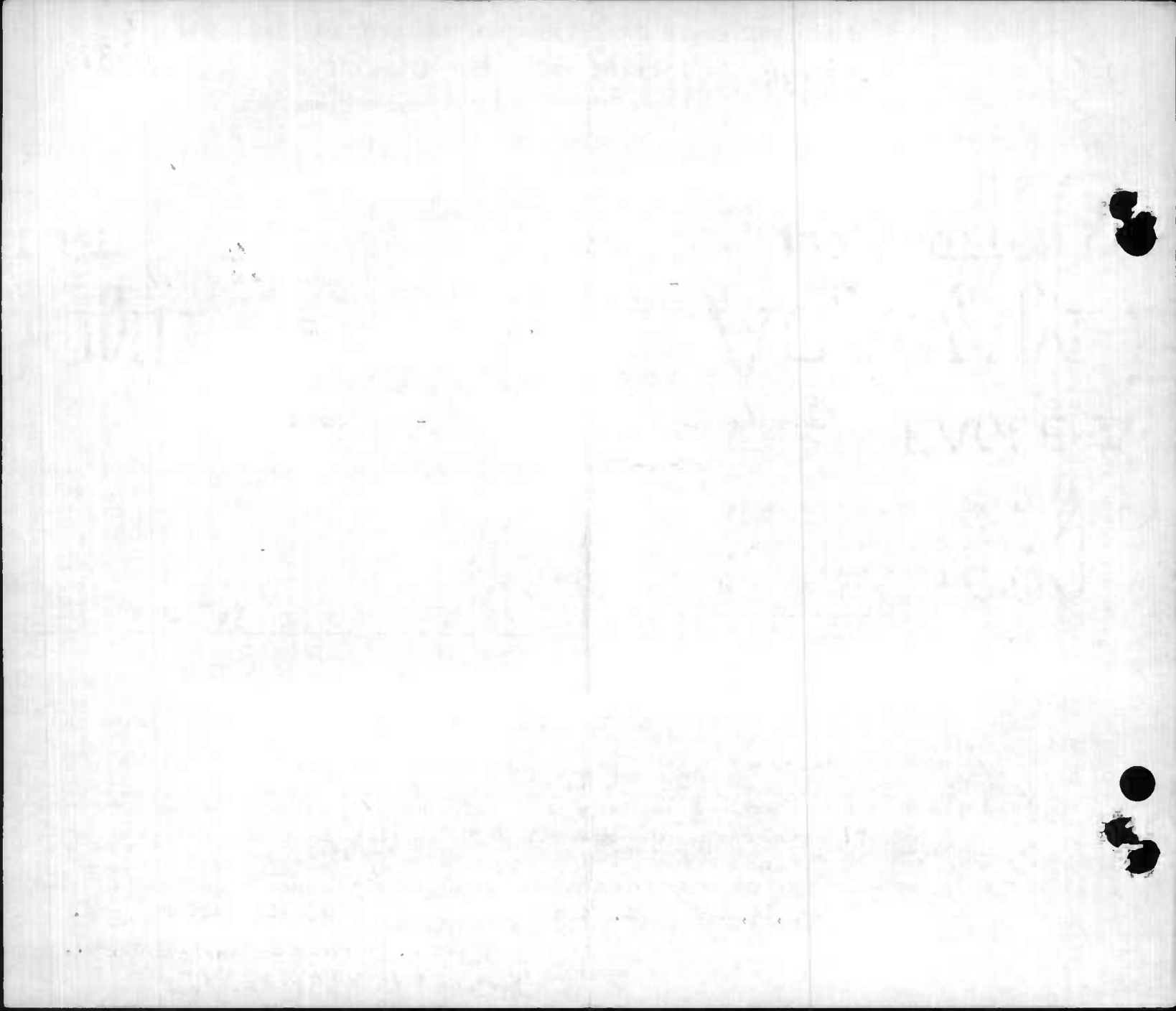
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Brandywine</u>		<u>6 weeks</u>		TOWN <u>Darlington</u>		<u>12 x - 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Home</u>		STREET ADDRESS (If rural give location)		<u>mm</u>	
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Pervis</u>		(Middle) <u>-</u>		(Last) <u>Burcham</u>		(Month) <u>5</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Aug. 7, 1905</u>	
9. AGE last birthday: <u>50</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>farmer</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Avery Burcham</u>				14. MOTHER'S MAIDEN NAME: <u>- Smoot</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>222-05-0066</u>		17. INFORMANT & ADDRESS: <u>Donald Schillinger - Brandywine, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Myocardial Infarction</u>							
Antecedent causes (s) (b) <u>Arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>hypertension</u>							
19a. DATE OF OPERATION: _____ 19b. MAJOR FINDINGS OF OPERATION _____							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-8</u> , 19 <u>56</u> , to <u>5-16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Dobson</u>				DATE SIGNED <u>5-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 14, 1956</u>		<u>Mt. Zion</u>		<u>Bel Air Harford Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
				<u>Howard K. McComas & Son, Abingdon, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5371

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 301 1/2 Swanton Road</u>		d. STREET ADDRESS <u>Route 301 1/2 Swanton Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Eppie</u> Middle <u>Calton</u> Last <u>?</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>56</u> Min.	IF UNDER 24 HRS. Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Emmet Carter</u> Address <u>Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemopericardium</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ruptured heart</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>?</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> o. m. <u>?</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>		20f. (City or town) (County) (State) <u>?</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>May 18, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 22 1956</u>	
ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Tanner</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH-BALDWIN 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACED IN THE HANDS OF THE

DEATH OF THIS DECEASED

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

RELIGION

PROFESSION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

RECEIVED
MAY 22 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05377

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>union</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND PARK</u>		c. LENGTH OF STAY IN 1b <u>3 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTFIELD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MARYLAND PARK High School</u>				d. STREET ADDRESS <u>528 CARLETON Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRASER</u> Middle <u>KEITH</u> Last <u>CAMERON</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 6, 1923</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher Education</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STUART CAMERON</u>				14. MOTHER'S MAIDEN NAME <u>RUTH WINTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO. <u>145-18-328</u>		17. INFORMANT Address <u>MRS. RUTH CAMERON SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun shot wound of chest</u> DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by a student</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5-4 PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School</u>		20f. (City or town) (County) (State) <u>West Park P.S. New Jersey</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 4, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westfield</u>		22d. LOCATION (City, town, or county) (State) <u>New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>			
24a. REC'D BY REGISTRAR <u>5-10-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

DATE

AGE

SEX

RESIDENCE

OCCUPATION

CAUSE OF DEATH

BUREAU V. 1

MAY 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05378
231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Dead on Arr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Malcolm</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				d. STREET ADDRESS 											
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Coates</u> Last <u>Coates</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1956</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>12-12-1901</u>		9. AGE (In years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>Horace Solomon</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>John Coates, Same address</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X Spontaneous intracranial hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebrovascular accident</u> (c) <u>Essential hypertension</u> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 											
20f. (City or town) 		(County) 		(State) 											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.															
ACTUAL SIGNATURE <u>John T. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>May 24, 1956</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Cem.</u>											
22d. LOCATION (City, town, or county) <u>Waldorf, Maryland</u>		(State) 													
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 25 1956</u>											
24b. REGISTRAR'S SIGNATURE <u>Amanda Bowrey</u>		DATE 													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

NEW YORK STATE DEPARTMENT OF HEALTH - MEMORANDUM
370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 29 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05379

5439

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale, Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10				d. STREET ADDRESS 2210 Charleston St.			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Rachel Last Cornis h				4. DATE OF DEATH Month May Day 4 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 7, 1876	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Johnathan D. Hunt				14. MOTHER'S MAIDEN NAME Elizabeth Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Jane C. Duvall				Address 2210 Charleston St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease DUE TO (c) arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yr 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bladensburg, Md.				20g. (County) Prince George		20h. (State) Md.	
21. I certify that I attended the deceased from Mar 2 , 19 56 to May 4 , 19 56 , that I last saw the deceased alive on April 27 , 19 56 , and that death occurred at 9 a. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Lee Spive				ADDRESS (Street, city or town, state) 4601 16th St, N.W. Wash D.C.			
PHYSICIAN'S NAME (Type) R. LEE SPIVE				DATE SIGNED May 6 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
22d. LOCATION (City, town, or county) Bladensburg, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Ga. Ave. Wash. D.C.		24a. REC'D BY REGISTRAR May 6 1956	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe				24c. (Signature) Severe			

1956 9 MAY

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5440

CERTIFICATE OF DEATH

05380

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>47X3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest-Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4500-Suitland Rd. SE.</u>		d. STREET ADDRESS <u>900-Ridge Rd. SE.</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES H. COWNE</u>		4. DATE OF DEATH <u>May 26 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1862 FEB 16, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POLICEMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Leroy J. Cowne</u>		Address <u>900-Ridge Rd. SE Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive failure</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>902.0</u> (b) <u>Fracture, intertrochanteric, left hip S.E.C.</u> DUE TO <u>6 week</u> (c) <u>Myocardial heart disease</u> DUE TO <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture, intertrochanteric, left hip</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fell off bed at home</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>April 16 1956</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington DC</u>	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 25, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest E. Cornelsen</u> M.D.		ADDRESS (Street, city or town, state) <u>4900 Bowen Rd. SE</u> DATE SIGNED <u>5/26/56</u>	
PHYSICIAN'S NAME (Type) <u>L</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee Sons Co - Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>May 29-56</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
James J. Connelley		45		Male		White		Roman Catholic	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
100 West 10th St., Boston, Mass.		July 27, 1956		Home		Myocardial Infarction		Natural	
OCCUPATION		EDUCATION		MARITAL STATUS		PREVIOUS ILLNESS		HISTORY OF DRUGS	
Carpenter		High School		Married		Hypertension		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
July 1, 1911		Boston, Mass.		N/A		N/A		N/A	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
July 27, 1956		Home		July 27, 1956		Home		July 27, 1956	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
July 27, 1956		Home		July 27, 1956		Home		July 27, 1956	

BUREAU V. E.

JUN 1 1956

RECEIVED

CERTIFICATE OF DEATH

See: Birth Cert.

5392

Reg. Dist. No.

0538645

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Heland Memorial</u>				d. STREET ADDRESS <u>3707 Windom Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby boy Cullinan</u>				4. DATE OF DEATH <u>MAY 20 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 19, 1956</u>	
9. AGE (In years last birthday) <u>11</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Edward Michael Cullinan</u>				14. MOTHER'S MAIDEN NAME <u>ANNA Elizabeth Bizer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hosp. records and Parents.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic chloasma of newborn</u> <u>771.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5-19-1956</u> , to <u>5-20-1956</u> , that I last saw the deceased alive on <u>5-20-1956</u> , and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Woodruff</u> M.D.				ADDRESS (Street, city or town, state)			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Wash DC</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Matthew Hamilton</u> ADDRESS <u>3831 E. 11th St</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. L. L. L.</u>	
DATE <u>May 20, 1956</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 23 1956

RECEIVED

5393

CERTIFICATE OF DEATH

Reg. Dist. No.

05382

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 3 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6515 Auburn Ave.				d. STREET ADDRESS 6515 Auburn Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Amelia Middle L. Last Dahler				4. DATE OF DEATH Month May Day 6 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 Nov. 1863	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Francis Gasch				14. MOTHER'S MAIDEN NAME Sophie Schram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Sophie Pickett		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 7 1/2 days 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease years (c) Arteriosclerosis Generalized years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bladensburg Pr. Geo. Md.				(County) (State)			
21. I certify that I attended the deceased from Jan 1, 19 56 to 5-6-56 , 19 56 , that I last saw the deceased alive on 4-29 , 19 56 , and that death occurred at 1 30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd DATE SIGNED 5-7-56 ACTUAL SIGNATURE Dayton O. Watkins M.D. Bladensburg Pr. Geo. Md. PHYSICIAN'S NAME (Type) Dayton O. Watkins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Pr. Geo. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR MAY 10 1956	
24b. REGISTRAR'S SIGNATURE James Jones							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR		DATE	
JAMES H. HARRIS		45		M		W		JAN 10 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS		JAN 10 1956	
FATHER		MOTHER		SPOUSE		CHILDREN		BROTHERS		SISTERS		EDUCATION		OCCUPATION		RELIGION		POLITICAL PARTY	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		JOHN H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		FARMER		METHODIST		DEMOCRAT	
BORN		DIED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR	
JAN 10 1956		JAN 10 1956		45		M		W		JAN 10 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS	
FATHER		MOTHER		SPOUSE		CHILDREN		BROTHERS		SISTERS		EDUCATION		OCCUPATION		RELIGION		POLITICAL PARTY	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		JOHN H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		FARMER		METHODIST		DEMOCRAT	

BUREAU V. S.

JAN 10 1956

RECEIVED

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G197 5-23-56 et

05383

CERTIFICATE OF DEATH

Reg. Dist. No. 231

5394

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First Middle Last <u>Dailey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W-</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 19, 1902</u> Age <u>53</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Maddox</u> Address <u>5155 T. St. SE Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Cerebral hemorrhage</u> DUE TO <u>Branchio pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 days</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Albert Roth</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Pasch's Sons</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Conway</u>	

5367

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. LENGTH OF STAY IN 1b 2.5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9007-48th Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Guy Milton Davis				4. DATE OF DEATH Month May 21, Day 19 Year 56.			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1898 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Washington Terminal				11. BIRTHPLACE (State or foreign country) Washington D.C.			
13. FATHER'S NAME Milton Harris				14. MOTHER'S MAIDEN NAME Anne Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-18-0126		17. INFORMANT Ella H. Harris College Park, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Dis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR 1956, to May 1956, that I last saw the deceased alive on 5-15-56, and that death occurred at 10 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.L. ETIENNE (OVER) M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 4713 Trayway Rd College Park 5/24/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Kasch's Sons Hyattsville, Md				24a. REC'D BY REGISTRAR DATE 5/24/56		24b. REGISTRAR'S SIGNATURE Amanda Downey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner
Notified 5/24/56

10
Allert
5/24/56

RECEIVED

MAY 29 1956

BUREAU V. 8

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - BUTTE 18

5372 CERTIFICATE OF DEATH

Reg. Dist. No. 225

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince George</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	STATE <u>Md.</u> COUNTY <u>Mt.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
OR TOWN <u>Hyattsville</u>	LENGTH OF STAY (in this place)	OR TOWN <u>Silver Spring</u>	1556.2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Home</u>		STREET ADDRESS (If rural give location) <u>1112. Belvidere Court</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>SALLIE. A. DEALE</u>		OF DEATH: <u>MAY. 5th</u> 19 <u>56</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 30th 1881</u>
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country): <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	

13. FATHER'S NAME: <u>Rehars R. Mac Donald</u>		14. MOTHER'S MAIDEN NAME: <u>Mathilda Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Sacred Heart Home, Hyattsville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis with myocardial infarction</u>		<u>8 days</u>
ANTECEDENT CAUSE (S) (B) <u>Hypertensive heart disease</u>		<u>3 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1942 to 5/5/, 1956, that I last saw the deceased alive on 5/5/56, 1956, and that death occurred at 12:05 M, from the causes and on the date stated above.

SIGNATURE Thomas F Collins ADDRESS 322-H. St. N. E. D.C. DATE SIGNED 5/5/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>May 8th 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
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DATE REC'D BY LOCAL REGISTRAR <u>May 8 1956</u>	REGISTRAR'S SIGNATURE <u>James Severy</u>	24. FUNERAL DIRECTOR <u>J. F. Costello</u>	ADDRESS <u>1722 North Capitol St. Wash. D.C.</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5395

CERTIFICATE OF DEATH

05386

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesedon</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General Hospital</i>		d. STREET ADDRESS <i>4401 Baltimore Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Amanda</i> Middle <i>Downey</i> Last <i>Downey</i>		4. DATE OF DEATH Month <i>5</i> Day <i>27</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>UNKNOWN</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Patrick Sweeney</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Statistic Card</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170 X</i> DUE TO <i>Kidney</i> (b) <i>Cardio-renal arteriosclerotic heart</i> (c) <i>Ca. left breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/23</i> , 19 <i>56</i> , to <i>5/27</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>5/27</i> , 19 <i>56</i> , and that death occurred at <i>8:10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George Hageage</i>		DATE SIGNED <i>5/27/56</i>	
PHYSICIAN'S NAME (Type) <i>GEORGE HAGEAGE</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/29/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Paschi Sons Hyattsville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Amanda Downey</i>	
24a. REC'D BY REGISTRAR <i>5/31/56</i>		DATE	

BUREAU V. S.

MAY 31 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05387

5396

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412-60th Ave</u>				d. STREET ADDRESS <u>412-60th Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>G.</u> Last <u>ELKON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Pete Gaberman</u>				14. MOTHER'S MAIDEN NAME <u>Minnie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-03-3565</u>		17. INFORMANT <u>412-60th Ave</u> <u>Capitol Heights Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular</u> 10 years DUE TO (c) <u>Renal Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>four months</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>46</u> , to <u>May 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 Central Ave, Capitol Hgts Md 20746</u> DATE SIGNED <u>5/4/56</u> ACTUAL SIGNATURE <u>William Brainin</u> PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Cap. Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Wash., D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyarsky & Son</u> ADDRESS <u>3501 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE 5-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5397

CERTIFICATE OF DEATH

Reg. Dist. No.

05388

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Gen. Hosp</u>		d. STREET ADDRESS <u>5014-Sumner set Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Ray</u> Last <u>EVANS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 May 56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fred MARVIN EVANS</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Cannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity (5 1/2 mos)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:10</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. S. Clayman</u> M.D.		ADDRESS (Street, city or town, state) <u>6311 Balduy Road</u> DATE SIGNED <u>5/25/56</u>	
PHYSICIAN'S NAME (Type) <u>D. S. Clayman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE May 27, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

2077263XVI

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

5441

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 3 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2416 Kenton Place				d. STREET ADDRESS 2416 Kenton Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maude Virginia Fanning				4. DATE OF DEATH Month Day Year May 26 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 5, 1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gum Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Akers				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Frank L Fanning same addr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self from iron garden in basement					
20c. TIME OF INJURY Month, Day, Year a. m. 5-25 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hillcrest Heights P.G. Co. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL				22b. DATE THEREOF May 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Suitland, Md				22e. REC'D BY REGISTRAR DATE May 28, 1956		24b. REGISTRAR'S SIGNATURE Edna T. Collins	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. I Altman				ADDRESS 3619 + 14 NW		DATE	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

JUN 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G197 5-24-56 et

5398

CERTIFICATE OF DEATH

05390

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>320 Laurel Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Fox</u> Last <u>Fox</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Race Horse Trainer</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>	
13. FATHER'S NAME <u>? Fox</u>		14. MOTHER'S MAIDEN NAME (same as married name) <u>Alinda Fox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 1917-18</u>	
17. INFORMANT <u>Mrs. Mary Rebecca Lowery</u>		Address <u>Laurel, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction, Right</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal Distention</u> DUE TO (c) <u>1 week</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> , to <u>May 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>56</u> , and that death occurred at <u>5:15 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.		DATE SIGNED <u>May 14, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. Wingfield</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 17, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Donaldson</u> ADDRESS <u>MD</u>		24a. REC'D BY REGISTRAR <u>5/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>Alinda Fox</u>

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Thomas Franklin</i>		AGE <i>78</i>		SEX <i>M</i>		RACE <i>W</i>	
DATE OF DEATH <i>May 21 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Heart failure</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>May 13 1878</i>		PLACE OF BIRTH <i>Harford</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
FATHER'S NAME <i>John Thomas Franklin</i>		MOTHER'S NAME <i>Elizabeth Franklin</i>		FATHER'S OCCUPATION <i>Farmer</i>		MOTHER'S OCCUPATION <i>Homemaker</i>	
DECEASED'S RESIDENCE <i>1234 Main St, Baltimore, MD</i>		DECEASED'S RELIGION <i>Methodist</i>		DECEASED'S MARITAL STATUS <i>Married</i>		DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i>	
DECEASED'S PRESENT ADDRESS <i>1234 Main St, Baltimore, MD</i>		DECEASED'S PRESENT PHONE NUMBER <i>123-4567</i>		DECEASED'S PRESENT MAILING ADDRESS <i>1234 Main St, Baltimore, MD</i>		DECEASED'S PRESENT MAILING PHONE NUMBER <i>123-4567</i>	
DECEASED'S PRESENT EMPLOYER <i>None</i>		DECEASED'S PRESENT EMPLOYER'S ADDRESS <i>None</i>		DECEASED'S PRESENT EMPLOYER'S PHONE NUMBER <i>None</i>		DECEASED'S PRESENT EMPLOYER'S MAILING ADDRESS <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S CITY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S COUNTY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S STATE <i>None</i>		DECEASED'S PRESENT EMPLOYER'S ZIP CODE <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S COUNTRY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S DEPARTMENT <i>None</i>		DECEASED'S PRESENT EMPLOYER'S DIVISION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S SECTION <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S UNIT <i>None</i>		DECEASED'S PRESENT EMPLOYER'S POSITION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S GRADE <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CLASS <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S RANK <i>None</i>		DECEASED'S PRESENT EMPLOYER'S RATE <i>None</i>		DECEASED'S PRESENT EMPLOYER'S PAY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S BENEFIT <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S ALLOWANCE <i>None</i>		DECEASED'S PRESENT EMPLOYER'S RETIREMENT <i>None</i>		DECEASED'S PRESENT EMPLOYER'S PENSION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S ANNUITY <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S GRATUITY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S COMPENSATION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S INDEMNITY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S INSURANCE <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S SAVINGS <i>None</i>		DECEASED'S PRESENT EMPLOYER'S INVESTMENT <i>None</i>		DECEASED'S PRESENT EMPLOYER'S ASSETS <i>None</i>		DECEASED'S PRESENT EMPLOYER'S LIABILITIES <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S NET WORTH <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT RATING <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT HISTORY <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT RECORD <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S CREDIT REPORT <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT REVIEW <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT ANALYSIS <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT SUMMARY <i>None</i>	
DECEASED'S PRESENT EMPLOYER'S CREDIT CONCLUSION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT RECOMMENDATION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT ACTION <i>None</i>		DECEASED'S PRESENT EMPLOYER'S CREDIT FOLLOW-UP <i>None</i>	

BUREAU V. S.

MAY 21 1956

RECEIVED

5399

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Reid</u> Middle <u>A</u> Last <u>Gibson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 May 1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railway X press</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas R. Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Helen J. S. ayers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mildred E. Gibson 24 Fowler Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MELANOCARCINOMA-LUNG-(METASTATIC)</u> <u>190X</u> DUE TO <u>LEFT HAND</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>PRIMARY-MELANOCARCINOMA</u> DUE TO <u>CHAND REMOVED AT J. HOPKINS (1950)</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RIGHT PNEUMONECTOMY-MAR-1956 P. H. HOSP CHEVERLY</u> <u>FOR-CARCINOMA</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 MOS</u> <u>6 Yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>56</u> , to <u>29 MAY</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 MAY</u> , 19 <u>56</u> , and that death occurred at <u>1255A M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				ADDRESS (Street, city or town, state) <u>3404 Cheverly Ave Cheverly, Md.</u>			
DATE SIGNED _____				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>				ADDRESS <u>3404 Cheverly Ave, Cheverly, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons</u> ADDRESS <u>300-4th St. D.C.</u>				24a. REC'D BY REGISTRAR <u>Carrie Campbell</u> DATE <u>May 31-56</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF VITAL RECORDS

BUREAU V. S.

JUN 4 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05392

Item 18 Film G198 6-15-56 ams

5442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Andrews AFB, Wash. 25, DC</u>	STATE <u>D.C.</u> COUNTY <u>Prince Georges</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington 23, SE</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1101st USAF Hospital, MATS Andrews AFB, Wash. 25, D.C.</u>	STREET ADDRESS (If rural give location) <u>3108 Parkway Terrace Drive, SE</u>		
3. NAME OF DECEASED: (First) <u>Charline</u> (Middle) <u>Joyce</u> (Last) <u>Graham</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 11 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6 February 1956</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NA</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NA</u>	9. AGE last birthday: <u>3</u> yrs. <u>5</u> Months <u>5</u> Days <u>11</u> Hours <u>5</u> Min.
13. FATHER'S NAME: <u>Roscoe Graham</u>		14. MOTHER'S MAIDEN NAME: <u>Charline J. Jordan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NA</u>	
17. INFORMANT & ADDRESS: <u>Roscoe Graham, 3108 Parkway Terrace Dr., S1</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>491X</u> <u>Suffocation</u>		-	
ANTECEDENT CAUSE (B) <u>Acute Bronchopneumonia</u>		24 hrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <u>8⁰⁰/A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Donald E. McElollum</u> M.D.		ADDRESS <u>Andrews AFB, Wash. 25, DC</u> DATE SIGNED <u>11 May 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-12-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>21 May 57</u>		REGISTRAR'S SIGNATURE <u>Helen M. Michalco</u>	
24. FUNERAL DIRECTOR <u>Rinaldi Funeral Home INC, 816 H St, Wash. D</u>		ADDRESS	

BUREAU V. S.

JUN 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5443

CERTIFICATE OF DEATH

05393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				d. STREET ADDRESS <u>6389-Rollins Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6389-Rollins Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Constance</u> First <u>Elma</u> Middle <u>Graham</u> Last				4. DATE OF DEATH <u>Apr 24</u> Month <u>21</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1905</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manicurist</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stiles Windom</u>				14. MOTHER'S MAIDEN NAME <u>Rose Welsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-24-0161</u>		17. INFORMANT <u>Elmer Morris</u> Address <u>Seat Pleasant</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno-Carcinoma Rt. Ovary</u> DUE TO <u>with multiple Metastases.</u> (c) <u>7 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 1955</u> , to <u>May 21, 1956</u> that I last saw the deceased alive on <u>5/20/1956</u> , and that death occurred at <u>12:24 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7200-MARLBORO PIKE SE. District Heights, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u>		M.D. <u>7200-MARLBORO PIKE SE.</u>		DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>S.W. LOWRY M.D.</u>		DISTRICT HEIGHTS, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moncks Corner</u>		22d. LOCATION (City, town, or county) (State) <u>South Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>5/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Cassie Campbell</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John J. ...</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>65 years</i></p>		<p>4. DATE OF DEATH <i>Nov. 23, 1956</i></p>	
<p>5. PLACE OF DEATH <i>At home</i></p>		<p>6. CAUSE OF DEATH <i>Heart - coronary artery disease</i></p>	
<p>7. PLACE OF BIRTH <i>Massachusetts</i></p>		<p>8. OCCUPATION <i>Retired</i></p>	
<p>9. MARITAL STATUS <i>Married</i></p>		<p>10. SIGNATURE OF DECEASED <i>(Signature)</i></p>	
<p>11. SIGNATURE OF WITNESS <i>(Signature)</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>(Signature)</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>(Signature)</i></p>		<p>14. SIGNATURE OF CLERK <i>(Signature)</i></p>	

RECEIVED
 MAY 23 1956
 BUREAU V. 2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
 BOSTON, MASS.

5382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3123-Queens Chapel Rd.				d. STREET ADDRESS 3123-Queens Chapel Rd.			
3. NAME OF DECEASED (Type or print) Cyrus First Middle Last Grissitt				4. DATE OF DEATH Month 5 Day 20 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1877	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter				10b. KIND OF BUSINESS OR INDUSTRY 719-01-2955		11. BIRTHPLACE (State or foreign country) W. Moulton Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address 3305-Children				Viola Henzel, Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks unknown unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 17th, 1953, to May 20, 1956, that I last saw the deceased alive on May 3, 1956, and that death occurred at 10:50 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. G. HADLEY				M.D. 1252 4th St S.W. Wash DC			
PHYSICIAN'S NAME (Type) H. G. HADLEY				DATE SIGNED May 20 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-23/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Elliott Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE May 22 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAY 24 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05395

5400

CERTIFICATE OF DEATH

Item 7, Film G198, 6/4/56 bh Item 7, Film G198 6-3-56 et.

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi, Md.</u>		d. STREET ADDRESS <u>2311 Apache St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roy DEAN</u> First Middle Last <u>Guindon</u>		4. DATE OF DEATH <u>May 24, 1956</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1910</u> 45 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Installer Telephone co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>new york</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wilford Guindon</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Spear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>100-100000-1000</u>	
17. INFORMANT <u>Mildred Guindon</u> Address <u>Adelphi Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myelogenous Leukemia</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Hrs</u> <u>< 1 YR</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>May 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 24</u> , 19 <u>56</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold A. Leach</u> M.D. <u>4314 Gallatin St</u>		DATE SIGNED <u>5/24/56</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEACH</u>		<u>Hyattsville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 26, 1956</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Oyster Bay</u>		22d. LOCATION (City, town, or county) (State) <u>new york</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gascha Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>5/26/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Winanda Downey</u>	

18

MAY 31 1956

RECEIVED
MAR 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH

05396

2411 N. Charles Street, Baltimore

5444

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 1417 Que St., N. W.	
3. NAME OF DECEASED (Type or Print) EMMETT		4. DATE OF DEATH 5 17 1956	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SEPARATED		8. DATE OF BIRTH 5.5.1998	
9. AGE last birthday 58 yrs.		10. BIRTHPLACE (State or foreign country) Louisia, Va	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harris		14. MOTHER'S MAIDEN NAME Emma Jane Daniel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. 577-14-7313	
17. INFORMANT AND ADDRESS Decedent			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 yr + 2 mo
18. MEDICAL CERTIFICATION		
Immediate cause (a) Bronchogenic carcinoma of right lung		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 9.21.55		19b. MAJOR FINDINGS OF OPERATION Bronchogenic carcinoma of right lung
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE HOMICIDE		22. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4.19, 1956, to 5.17, 1956, that I last saw the deceased alive on 5.17, 1956, and that death occurred at 8:09 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Hospital
Glenn Dale, MarylandDATE SIGNED
5/17/5623. BURIAL OR CREMATION
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/17/56

Wm Green

Rollins Funeral Home, 4339 Hunt St

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1956

BUREAU V. 8

CERTIFICATE OF DEATH

0539731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheerly</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Gen Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Harrod</u> Last <u>Harrod</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 Nov 1882</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBT HARROD</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA CRAWFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <u>7102-M ST. ANNIE HARROD - Mrs H. P. RO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate - gen. Septicemia</u> 1 year 177X DUE TO (b) <u>Carcinoma of the prostate</u> 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bronchopneumonia & emphysema</u> 24 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>May 17, 1956</u> to <u>May 19, 1956</u> , that I last saw the deceased alive on <u>May 19, 1956</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon W. Kelley</u> M.D. <u>6124 - 1st Ave N. Balt.</u>				DATE SIGNED <u>5/19/56</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stewart</u> ADDRESS <u>304 N. ST. NE.</u>				24a. REC'D BY REGISTRAR DATE <u>5/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Maranda Sweeney</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW HAMPSHIRE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. B.

MAY 23 1956

RECEIVED

5373

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4708 Banner St.		d. STREET ADDRESS 4708 Banner St.	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE HEHR		4. DATE OF DEATH May 24, 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 28, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 84
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Marie F. Heyn		Address Hyattsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Ca of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 mo 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-7, 1952 to 5-24, 1956 that I last saw the deceased alive on 5-25-56, 1956, and that death occurred at 4:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum M.D.		ADDRESS (Street, city or town, state) Hyattsville Md	
DATE SIGNED 5-28-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch sons		ADDRESS Hyattsville Md	
24a. REC'D BY REGISTRAR DATE May 28, 1956		24b. REGISTRAR'S SIGNATURE Mo. Jas. Severel	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 31 1956

BUREAU V.

RECEIVED

MARGIN RESERVED FOR BINDING

VS. A15 — 10 — 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1805399

5445 CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George		MARYLAND		STATE Md.		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		1556	
X Rural - Hyattsville 7 wk. 6 da				Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 Saint Branch Nursing Home				9929 Markham St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Carrie Alberta Higgins				May 20 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Fe	W	Widow	July 20, 1879	76 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
Housewife							
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Clarcona, Fla.				U. S. A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Stephen S. Tenn				Priscilla Jane Roberson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				none			
17. INFORMANT & ADDRESS:							
Lorraine Hark 9929 Markham St.				Silver Spring			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0							
IMMEDIATE CAUSE				(A) Interstitial pneumonia			
ANTECEDENT CAUSE (S):				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) Generalized severe arteriosclerosis 1 yr.			
				DUE TO head disease (C) Cerebral thromboses 1 yr.			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 , to May 20, 1956, that I last saw the deceased alive on May 18, 1956, and that death occurred at 5:50 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
Ernest E. Harmon M.D.				7301 Calverly Rd Silver Spring, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
TRANS. & BURIAL				5/22/56			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
CHULUOTA CEMETERY				SEMINOLE COUNTY, FLORIDA			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
6/22/56				Francis P. Foster			
				24. FUNERAL DIRECTOR			
				Warner E. Humphrey			
				ADDRESS			
				SILVER SPRING, MD.			

BUREAU V. 3

MAY 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 245

5402

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mid.</u> b. COUNTY <u>Prince Geor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4508 Church St.</u>		d. STREET ADDRESS <u>4508 Church St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Chatman</u> Last <u>Hobbs</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theophus Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Julia Chatman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Gladys Johnson</u> Address <u>4504 41st Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 2</u> , 1956, to <u>May 30</u> , 1956, that I last saw the deceased alive on <u>May 30</u> , 1956, and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sterling M. Lloyd</u> M.D.		ADDRESS (Street, city or town, state) <u>61 K St N.W.</u> DATE SIGNED <u>5/30/56</u>	
PHYSICIAN'S NAME (Type) <u>Sterling M. Lloyd</u>		<u>Washington DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Scutland Rd. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u> ADDRESS <u>467 N St. N.W. Wash.</u>		24a. REC'D BY REGISTRAR <u>DATE June 2 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Joe. Severe</u>

1
 AFTER DEATH: Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05401

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>10 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5611 Shadyside Avenue</u>				d. STREET ADDRESS <u>5611 Shadyside Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mayhugh</u> Middle <u>Harold</u> Last <u>Horne</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Wesley Horne</u>				14. MOTHER'S MAIDEN NAME <u>Rella Rodgers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1923</u>		17. INFORMANT <u>Mrs. Nora M. Horne</u> Address <u>Prince Frederick, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock.</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ruptured esophageal varix.</u> (c) <u>Cirrhosis of the liver.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DATE SIGNED <u>5-13-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16 - 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington National</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Brothers - 1666 - 9th Ave NE</u>				24a. REC'D BY REGISTRAR <u>May 14 56</u>		24b. REGISTRAR'S SIGNATURE <u>Edna F. Collins</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 18 - 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 10a, 11, 12, 13, 14, Filed 1975-15-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 237

05402

5403

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Brockbridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harvey Jackson			4. DATE OF DEATH May 8 1956				
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 85? yrs.		9. AGE (In years last birthday) 85? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 days years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 56 , to May 8 , 19 56 , that I last saw the deceased alive on May 8 , 19 56 , and that death occurred at 1:10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Albert Roth M.D. 5570 Main St. Annapolis 5/8/56 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. ADDRESS 901 3rd Street, S. W.				24a. REC'D BY REGISTRAR 5/11/56		24b. REGISTRAR'S SIGNATURE Monica Lowmyer	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MAY 11 1956

RECEIVED
MAY 11 1956

5368

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH o. COUNTY <u>Br. Leo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Br. Leo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
c. LENGTH OF STAY IN 1b <u>30 yr</u>		d. STREET ADDRESS <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9030 R.I. Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY Louise KEMP</u>		4. DATE OF DEATH <u>MAY 20</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1878</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Chas a Sparsholt</u>		14. MOTHER'S MAIDEN NAME <u>Emma Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-16-3085</u>	
17. INFORMANT <u>Carola Cephshaw</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5-18</u> , 19 <u>56</u> , to <u>5-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19-56</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.L. Etienne</u>		M.D. <u>47/3 - Berwyn Rd</u>	
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		ADDRESS (Street, city or town, state) <u>College Park, Md</u> DATE SIGNED <u>5/20/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO. - RIVERDALE MD</u>		24a. REC'D BY REGISTRAR <u>John D. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 24 1956

RECEIVED

5-25-56

1. NAME OF DECEASED [Faint handwritten name]		2. SEX [Faint handwritten sex]		3. AGE [Faint handwritten age]		4. DATE OF BIRTH [Faint handwritten date]	
5. PLACE OF BIRTH [Faint handwritten place]		6. OCCUPATION [Faint handwritten occupation]		7. MARITAL STATUS [Faint handwritten status]		8. CAUSE OF DEATH [Faint handwritten cause]	
9. MEDICAL HISTORY [Faint handwritten history]		10. PRESENT ILLNESS [Faint handwritten illness]		11. TIME OF DEATH [Faint handwritten time]		12. PLACE OF DEATH [Faint handwritten place]	
13. SIGNATURE OF DECEASED [Faint handwritten signature]		14. SIGNATURE OF WITNESS [Faint handwritten signature]		15. SIGNATURE OF PHYSICIAN [Faint handwritten signature]		16. SIGNATURE OF CLERK [Faint handwritten signature]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5494

CERTIFICATE OF DEATH

05404

239

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>Pennsylvania</u> COUNTY <u>75K-3</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hanover</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>				STREET ADDRESS (If rural give location) <u>121 Carlisle Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mae Adelaide KuHN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 24, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Adams Co. Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward J. KuHN</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hilt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unit) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>121 Carlisle St. Hanover, Pa.</u>		17. INFORMANT'S NAME & ADDRESS <u>Mrs. Eliz. K. Smith</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>						<u>Several yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>General Arteriosclerosis</u>						<u>Many yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 28, 19 53</u> , to <u>May 16, 19 56</u> , that I last saw the deceased alive on <u>May 15, 19 56</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph T. Keenan</u> M.D.				ADDRESS (Street, city, town, state) <u>Laurel, Maryland</u>		DATE SIGNED <u>May 16, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 19, 19 56</u>		NAME OF CEMETERY OR CREMATORY <u>Crownway Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crownway Adams Co. Pa.</u>	
24. REC'D BY REGISTRAR <u>May 16-56</u>		REGISTRAR'S SIGNATURE <u>M. Brashears</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Keenan</u>		ADDRESS <u>Northampton, Pa.</u>	

BUREAU V. S.

MAY 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Date 054953/

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>409-70th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Laurence William King</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Deputy Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ruth King same as no 11</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>May 22, 1956</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <u>Burial May 25, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Curlington National</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasci same as Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>5/24/56</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Downing</u>	

TO DEFUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any other necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

MAY 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05406

5406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNT <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 Prince Georges General Hosp.</u>				d. STREET ADDRESS <u>6109 Kolb St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilson Lashley</u>				4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 25, 1927</u>		9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Luther Lashley</u>			
14. MOTHER'S MAIDEN NAME <u>Victoria Anderson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mattie Lashley</u>		<u>405 - G - St. S.E.</u> <u>Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Gunshot wound of chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wounded by a bullet from a gun.</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>xx</u> p.m. <u>5-10-56</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Fairmount Hts., Pr. Geo. Md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>5/11/56</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>5-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke Rapids N.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington</u>		ADDRESS <u>Some 467 N 1st Ave</u>		24a. REC'D BY REGISTRAR <u>5-17-56</u>			
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		24c. REGISTRAR'S SIGNATURE <u> </u>					

TO DEED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAINTAIN STATE DEPARTMENT OF HEALTH - BUREAU OF
34 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
OFFICE OF EXAMINER		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

BUREAU V. S.

MAY 16 1956

RECEIVED

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 5447
 CERTIFICATE OF DEATH

05407

Reg. Dist. No. 142

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Virginia b. COUNTY Webster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camden on Gauley 85 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5405 Shady Side Ave.		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) OKEY First SIMPSON Middle LAW Last		4. DATE OF DEATH May 17 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1875
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT L.B. Law		Address 5405 Shady Side Ave Suitland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1956, to May 17, 1956, that I last saw the deceased alive on May 15, 1956, and that death occurred at 8:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James I. Boyd M.D. 8200 Merchants Park A? PHYSICIAN'S NAME (Type) JAMES I. Boyd Washington 28, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/19/56	
22c. NAME OF CEMETERY OR CREMATORY Schaffer Cemetery		22d. LOCATION (City, town, or county) (State) Camden on Gauley, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lees Sons Co. 300 4th St N.E. D.C.		24a. REC'D BY REGISTRAR May 20 56	
24b. REGISTRAR'S SIGNATURE Edna F. Collins			

BUREAU V. S.

MAY 24 1956

RECEIVED

5220411

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05408**
232

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE Washington b. COUNTY D.C.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			c. LENGTH OF STAY IN 1b one hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Circuit Court Room.				d. STREET ADDRESS 4705 Colorado Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nathan Middle Levin Last Levin				4. DATE OF DEATH Month May Day 12 Year 1956				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1898		
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor			10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Conn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Levin				14. MOTHER'S MAIDEN NAME Hinda Platties				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Abraham H. Levin 409 Pershing Drive Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
22. BURIAL, CREMATION, REMOVAL (Specify) May 14-1956 BNA				22b. DATE THEREOF May 14-1956		22c. NAME OF CEMETERY OR CREMATORY ISRAEL Cem		
22d. LOCATION (City, town, or county) Oxon Hill MD				22e. (State) MD				
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home				23b. ADDRESS 4217-9th Ave Wash. DC		24a. REC'D BY REGISTRAR DATE May 14 1956		
24b. REGISTRAR'S SIGNATURE John F. Danner								

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

May 12, 1956

DATE SIGNED

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
355? MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. BROWN		SEX Male	
AGE 45		DATE OF BIRTH 1910	
PLACE OF BIRTH BOSTON, MASS.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE 1935	
NAME OF SPOUSE MARY E. BROWN		ADDRESS 123 Main St., Boston, Mass.	
CAUSE OF DEATH Myocardial Infarction		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		DATE OF DEATH May 15, 1956	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF DECEASED [Signature]	

BUREAU V. S.

MAY 16 1956

RECEIVED

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05409

5449

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Lanham		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West Lanham Speedway			d. STREET ADDRESS 7007 Farragut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Silas Lindsay Lockhart, Jr.			4. DATE OF DEATH Month May Day 14 Year 19 56		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1918		9. AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant			10b. KIND OF BUSINESS OR INDUSTRY		IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Silas Lindsay Lockhart, Sr.			14. MOTHER'S MAIDEN NAME Lula Blankenship		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. W W 11 229-18-0617		
17. INFORMANT Eloise Lockhart, Same address			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Shotgun wound of head (c) DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound.			
20c. TIME OF INJURY Month, Day, Year Hour 11 p. m. 5-14- 1956		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) W. Lanham, Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		May 14, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington	
23. FUNERAL DIRECTOR'S SIGNATURE Charles sons Hyattsville Md		ADDRESS Hyattsville Md		24a. REC'D BY REGISTRAR DATE 5-22-56	
				24b. REGISTRAR'S SIGNATURE Wm. Agnes M. Yingling	

MISSOURI STATE DEPARTMENT OF HEALTH - EASTGORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
May 20, 1956		St. Louis, Mo.		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. B.

MAY 25 1956

RECEIVED

5450

CERTIFICATE OF DEATH

05410

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES, MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>M</u> Middle <u>Long</u> Last		4. DATE OF DEATH <u>5</u> - <u>3</u> - <u>1956</u> Month Day Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENIS LONG</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SHEEHAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HARVEY LYNN</u> Address <u>4765 WEST AVE 28 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>General Arteriosclerosis</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> , to <u>May 3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>May 3</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.		DATE SIGNED <u>May 3 1956</u>	
PHYSICIAN'S NAME (Type) <u>Paul C Van Natta</u>		<u>Washington 28 DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>5-7-56</u>	<u>MT. OLIVET Cemetery</u>	<u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALSH FUNERAL HOME-741-11th</u> ADDRESS		24a. REC'D BY REGISTRAR <u>8</u> DATE	24b. REGISTRAR'S SIGNATURE <u>A. St. Hedrick</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JURY</p>		<p>19. SIGNATURE OF JUDGE</p>		<p>20. SIGNATURE OF CLERK</p>	
<p>21. SIGNATURE OF SHERIFF</p>		<p>22. SIGNATURE OF DEPUTY SHERIFF</p>		<p>23. SIGNATURE OF CONSTABLE</p>		<p>24. SIGNATURE OF TOWN CLERK</p>	
<p>25. SIGNATURE OF TOWN ENGINEER</p>		<p>26. SIGNATURE OF TOWN CHURCH</p>		<p>27. SIGNATURE OF TOWN SCHOOL</p>		<p>28. SIGNATURE OF TOWN OFFICE</p>	
<p>29. SIGNATURE OF TOWN CHURCH</p>		<p>30. SIGNATURE OF TOWN SCHOOL</p>		<p>31. SIGNATURE OF TOWN OFFICE</p>		<p>32. SIGNATURE OF TOWN CHURCH</p>	
<p>33. SIGNATURE OF TOWN SCHOOL</p>		<p>34. SIGNATURE OF TOWN OFFICE</p>		<p>35. SIGNATURE OF TOWN CHURCH</p>		<p>36. SIGNATURE OF TOWN SCHOOL</p>	
<p>37. SIGNATURE OF TOWN OFFICE</p>		<p>38. SIGNATURE OF TOWN CHURCH</p>		<p>39. SIGNATURE OF TOWN SCHOOL</p>		<p>40. SIGNATURE OF TOWN OFFICE</p>	
<p>41. SIGNATURE OF TOWN CHURCH</p>		<p>42. SIGNATURE OF TOWN SCHOOL</p>		<p>43. SIGNATURE OF TOWN OFFICE</p>		<p>44. SIGNATURE OF TOWN CHURCH</p>	
<p>45. SIGNATURE OF TOWN SCHOOL</p>		<p>46. SIGNATURE OF TOWN OFFICE</p>		<p>47. SIGNATURE OF TOWN CHURCH</p>		<p>48. SIGNATURE OF TOWN SCHOOL</p>	
<p>49. SIGNATURE OF TOWN OFFICE</p>		<p>50. SIGNATURE OF TOWN CHURCH</p>		<p>51. SIGNATURE OF TOWN SCHOOL</p>		<p>52. SIGNATURE OF TOWN OFFICE</p>	
<p>53. SIGNATURE OF TOWN CHURCH</p>		<p>54. SIGNATURE OF TOWN SCHOOL</p>		<p>55. SIGNATURE OF TOWN OFFICE</p>		<p>56. SIGNATURE OF TOWN CHURCH</p>	
<p>57. SIGNATURE OF TOWN SCHOOL</p>		<p>58. SIGNATURE OF TOWN OFFICE</p>		<p>59. SIGNATURE OF TOWN CHURCH</p>		<p>60. SIGNATURE OF TOWN SCHOOL</p>	
<p>61. SIGNATURE OF TOWN OFFICE</p>		<p>62. SIGNATURE OF TOWN CHURCH</p>		<p>63. SIGNATURE OF TOWN SCHOOL</p>		<p>64. SIGNATURE OF TOWN OFFICE</p>	
<p>65. SIGNATURE OF TOWN CHURCH</p>		<p>66. SIGNATURE OF TOWN SCHOOL</p>		<p>67. SIGNATURE OF TOWN OFFICE</p>		<p>68. SIGNATURE OF TOWN CHURCH</p>	
<p>69. SIGNATURE OF TOWN SCHOOL</p>		<p>70. SIGNATURE OF TOWN OFFICE</p>		<p>71. SIGNATURE OF TOWN CHURCH</p>		<p>72. SIGNATURE OF TOWN SCHOOL</p>	
<p>73. SIGNATURE OF TOWN OFFICE</p>		<p>74. SIGNATURE OF TOWN CHURCH</p>		<p>75. SIGNATURE OF TOWN SCHOOL</p>		<p>76. SIGNATURE OF TOWN OFFICE</p>	
<p>77. SIGNATURE OF TOWN CHURCH</p>		<p>78. SIGNATURE OF TOWN SCHOOL</p>		<p>79. SIGNATURE OF TOWN OFFICE</p>		<p>80. SIGNATURE OF TOWN CHURCH</p>	
<p>81. SIGNATURE OF TOWN SCHOOL</p>		<p>82. SIGNATURE OF TOWN OFFICE</p>		<p>83. SIGNATURE OF TOWN CHURCH</p>		<p>84. SIGNATURE OF TOWN SCHOOL</p>	
<p>85. SIGNATURE OF TOWN OFFICE</p>		<p>86. SIGNATURE OF TOWN CHURCH</p>		<p>87. SIGNATURE OF TOWN SCHOOL</p>		<p>88. SIGNATURE OF TOWN OFFICE</p>	
<p>89. SIGNATURE OF TOWN CHURCH</p>		<p>90. SIGNATURE OF TOWN SCHOOL</p>		<p>91. SIGNATURE OF TOWN OFFICE</p>		<p>92. SIGNATURE OF TOWN CHURCH</p>	
<p>93. SIGNATURE OF TOWN SCHOOL</p>		<p>94. SIGNATURE OF TOWN OFFICE</p>		<p>95. SIGNATURE OF TOWN CHURCH</p>		<p>96. SIGNATURE OF TOWN SCHOOL</p>	
<p>97. SIGNATURE OF TOWN OFFICE</p>		<p>98. SIGNATURE OF TOWN CHURCH</p>		<p>99. SIGNATURE OF TOWN SCHOOL</p>		<p>100. SIGNATURE OF TOWN OFFICE</p>	

BUREAU V. S.

MAY 8 1950

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05411

5497 **CERTIFICATE OF DEATH**Reg. Dist. No. 739

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		LENGTH OF STAY (in this place) <u>4 1/2 mo. 17 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Valley</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		STREET ADDRESS (If rural give location) <u>5304 Valley Road S.E.</u>					
3. NAME OF DECEASED (Type or Print) <u>Pauline (MAM) Maciejowski</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>June 17, 1890</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Sandercki</u>				14. MOTHER'S MAIDEN NAME <u>ANTONIA SNIADANKO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u> </u> INFORMANT'S ADDRESS <u>Daughter Mary Wheatley 5304 Valley Rd Wash.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic Endocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				" <u> </u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arteriosclerosis with</u>				" <u> </u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-17</u> , 19 <u>56</u> , to <u>5-4</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5-3</u> , 19 <u>56</u> , and that death occurred at <u>11:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Jesse C. Higgins</u> M.D.				ADDRESS (Street, city, town, state) <u>Laurel, Maryland</u> DATE SIGNED <u>May 4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (city, town, or county) (State) <u>Suitland Pk. Co. Co. Md</u>	
24. REC'D BY REGISTRAR <u> </u> DATE <u>18 1956</u>		REGISTRAR'S SIGNATURE <u>Mollie Bushner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		ADDRESS <u>Riverside, Md.</u>	

CERTIFICATE OF DEATH

1956 MAY 8

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 11 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		PLACE OF BIRTH	
Salesman		Memphis, Tenn.	
CAUSE OF DEATH		MANNER OF DEATH	
Myocardial Infarction		Natural	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
Coronary Atherosclerosis		Coronary Atherosclerosis	
DURATION OF ILLNESS		PLACE OF DEATH	
24 hours		St. Louis, Mo.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		PLACE	
MAY 11 1968		St. Louis, Mo.	

BUREAU V. 2

MAY 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05412

Reg. Dist. No.

5408

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Island Memorial				d. STREET ADDRESS University Park			
3. NAME OF DECEASED (Type or print) DAISY Virginia Madary				4. DATE OF DEATH Month MAY Day 6 Year 1956			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1893	9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch Marshall Lewis				14. MOTHER'S MAIDEN NAME Emily Rebecca Burk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GEN. ARTERIOSCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 MO. 15 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from MARCH 16, 1953 , to MAY 6, 1956 , that I last saw the deceased alive on MAY 5, 1956 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Carl J. Hounmann M.D.				ADDRESS (Street, city or town, state) 4404 QUEENSBURY RD. RIVERDALE MD.			
DATE SIGNED 5-6-56				DATE SIGNED			
PHYSICIAN'S NAME (Type) L.W. MALIN, M.D. + C.J. HOUNANN M.D.				RIVERDALE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 8-56		22c. NAME OF CEMETERY OR CREMATORY Jacksonville		22d. LOCATION (City, town, or county) (State) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. - 2136th St, Baltimore, Md.				ADDRESS per ms.		24a. REC'D BY REGISTRAR MAY 10 1956	
				24b. REGISTRAR'S SIGNATURE James J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

First Name: George
Last Name: Riverdale
Age: 3 yrs
Sex: Male
Race: White
Marital Status: Single
Occupation: Unknown
Cause of Death: Unknown
Date of Death: May 10, 1956
Place of Death: Hospital
Physician: Dr. J. H. [illegible]
Manner of Death: [illegible]

RECEIVED
MAY 10 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05413
231
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly			c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Prince Georges General Hosp.				d. STREET ADDRESS 3133 Queens Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Samuel Last Mays				4. DATE OF DEATH Month May Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-01		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. Driving Instructor			10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Reuben Calvin Mays				14. MOTHER'S MAIDEN NAME Annie C. Bartow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 211-03-2931		17. INFORMANT Margaret J. Mays, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured bronchial artery (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2901 14th St. N.W.				24a. REC'D BY REGISTRAR 5/12/56		24b. REGISTRAR'S SIGNATURE Amanda Dourney	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute it in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 15 1956

RECEIVED

5451

CERTIFICATE OF DEATH

Reg. Dist. No. 142...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oxon Hill</u>		LENGTH OF STAY (in this place) <u>18 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Oxon Hill</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>4654 Cedar Ridge Dr</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Lathrop MEAKER</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 25 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Aug 16 1878</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Writer</u>		11. BIRTHPLACE (State or foreign country): <u>Pa.</u>	
13. FATHER'S NAME: <u>Arthur E. Meaker</u>				14. MOTHER'S MAIDEN NAME: <u>ANNA A. E. Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs James W. Davisson</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				332X			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				4 wks +			
ANTECEDENT CAUSE (S) (B) <u>Arterio sclerosis</u>				1 yr +.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16, 1956</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 16, 1956</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm W Burt Baker</u>				ADDRESS <u>M.D. 1635 Harvard St Wash. D.C.</u>		DATE SIGNED <u>5-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 28, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Nisley Hill Cem</u>		LOCATION (City, town, or county) (State) <u>Bethlehem Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 28-56</u>		REGISTRAR'S SIGNATURE <u>Harrie Campbell</u>		24. FUNERAL DIRECTOR <u>J. Wm. Sees Jones Co</u>		ADDRESS <u>300 4th St N.E. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1956

RECEIVED

CERTIFICATE OF DEATH

05415

Reg. Dist. No. 248

5374

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hyattsville Convalescent</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>J.</u> Last <u>MEEHAN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4/1869</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker U.S. Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newark, N.J.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John J. Meehan</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John J. Meehan, Jr.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>425.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic central vascular disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>56</u> , to <u>May 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>56</u> , and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1704 Michigan Ave., N.E.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u> M.D.				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR., M.D.</u>				ADDRESS <u>Washington 17, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u> <u>3200 - E. 2 Ave</u> <u>Mt. Rainier, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>May 17, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> <u>Deputy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORONER NOTIFIED AND WILL APPROVE.

J. F. Brennan Jr. M.D.

BUREAU V. S.

MAY 21 1956

RECEIVED

5375

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				d. STREET ADDRESS 5403 41st. Street, N. W.			
3. NAME OF DECEASED (Type or print) First ROSE Middle V. Last MERRILL				4. DATE OF DEATH Month MAY Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1863		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin John Merrill				14. MOTHER'S MAIDEN NAME Mary Cassidy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Agnes Chase 5403 41st St. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 1 min OK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1956 to May 20, 1956 , that I last saw the deceased alive on May 20, 1956 , and that death occurred at 1:30p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. W. CULVER C. W. CULVER, M.D.				DATE SIGNED May 20, 1956			
PHYSICIAN'S NAME (Type) 5713 Chevy Chase Parkway, N. W. WASHINGTON, D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins #3821				ADDRESS 14th. St. Wash. D.C.		24a. REC'D BY REGISTRAR May 22, 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. J. J. Severe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

05417

2411 N. Charles Street, Baltimore

5452

CERTIFICATE OF DEATH

Reg. Dist. No. 242

Item 9, Film GL97 5-11-56 et

1. PLACE OF DEATH: COUNTY <u>Pr. George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chapel Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9005 Old Fort Rd SE</u>		STREET ADDRESS (If rural, give location) <u>2210 Lexington St.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>John</u>	<u>Haven</u>	<u>Middleton</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4, 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. DATE OF DEATH <u>May 2, 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister - Methodist Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johns Island South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Timothy Middleton</u>		14. MOTHER'S MARDEN NAME <u>Julia Dickenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Julia M. Wright.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X Immediate cause

(a)

Myocardial Failure

INTERVAL BETWEEN ONSET AND DEATH

10 days

Antecedent cause(s)

(b)

Right Hemiplegia5 1/2 wks.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cerebral Arterio Sclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Decubitus Ulcer

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 21, 1956, to May 2, 1956, that I last saw the deceasedalive on May 1, 1956, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Anna Coppe Todd, M.D. 7519 Broadview Rd SE Pr. Geo. County 5/2/56

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 2-1956 Edna F. Sollman John T. Rhines & Co. 901-3rd St. S.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

MAY 7 1956

RECEIVED

BUREAU V. S.

MAY 8 1956

RECEIVED

TO POSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5410

CERTIFICATE OF DEATH

05419

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11215 - Carlina Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince Georges Gen. Hosp.				d. STREET ADDRESS Beltsville, Md.			
3. NAME OF DECEASED (Type or print) Roger Anthony Nagel				4. DATE OF DEATH May 16, 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/30/51	
9. AGE (In years last birthday) 4		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George H. Nagel				14. MOTHER'S MAIDEN NAME Lois A. Meininger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT George H. Nagel				Address Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 085,1 Generalized Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho-pneumonia + empyema DUE TO + lung abscess (c) Rubella INTERVAL BETWEEN ONSET AND DEATH 12 hrs. - 24 hrs. - 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE W. L. Etienne M.D. ADDRESS 4712 Kennedy Blvd. DATE SIGNED PHYSICIAN'S NAME (Type) W. L. ETIENNE College Park, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.				ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 5/18/56	

MAY 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05420

5411

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chervaly c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights d. STREET ADDRESS 201 Standish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Nelson		4. DATE OF DEATH Month Day Year May 12 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Alabama			
13. FATHER'S NAME Washington Nelson		14. MOTHER'S MAIDEN NAME Elizabeth Richie		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James C. Nelson - 1st & V Sts. S.W. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 Days. 1 Year				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)			
21. I certify that I attended the deceased from Apr 26, 1956 to May 13, 1956 , that I last saw the deceased alive on 5/13/56 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Samuel J. N. Sugar M.D. ADDRESS (Street, city or town, state) Mt Rainier, Md DATE SIGNED 5/13/56 PHYSICIAN'S NAME (Type) Samuel J..N. Sugar, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS 2901 14th St.		24a. REC'D BY REGISTRAR 5/15/56 24b. REGISTRAR'S SIGNATURE Monanda L...			
Washington, Dc.							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		11-11-1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. Street, Baltimore, Md.		Police Officer		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
May 12, 1956		Home		10:00 AM		Normal	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		TIME	
J. H. Harris		J. H. Harris		May 12, 1956		10:00 AM	

BUREAU V. S.

MAY 17 1956

RECEIVED

5376

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2417 Lyndon St.		d. STREET ADDRESS 2417 Lyndon St.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CLARENCE NICHOLSON		4. DATE OF DEATH Month Day Year May 12 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 30, 1864
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	11. BIRTHPLACE (State or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter Nicholson		14. MOTHER'S MAIDEN NAME Mary Botler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth B. Nicholson		Address Hyattsville 2417 Lyndon St. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CARDIAC FAILURE (b) ATHEROSCLEROTIC HEART DISEASE (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 3, 1956 to May 12, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6826 Egg St. Hyattsville Md ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) H. WAYNE CLICKFIELD MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lees Sons Co.		ADDRESS 300 4th St N.E. D.C.	
24a. REC'D BY REGISTRAR May 15 1956		24b. REGISTRAR'S SIGNATURE Mrs. J. A. Severel	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
WILLIAM NICHOLSON		MAY 17 1956		BALTIMORE, MD.	
Age		Sex		Race	
60		Male		White	
Married		Occupation		Cause of Death	
Yes		None		Heart Disease	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Name of Informant	
MAY 17 1956		BALTIMORE, MD.		WILLIAM NICHOLSON	

BUREAU V. S.

MAY 17 1956

RECEIVED

5377

CERTIFICATE OF DEATH

Reg. Dist. 15422

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6403 Ager Road</u>				d. STREET ADDRESS <u>6122-54th Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Gwendolyn</u> Middle <u>Sue</u> Last <u>Nutzman</u>				4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 31, 1955</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Georges</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Blouis Nutzman</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Radloff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>microcephaly</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>forencephaly</u> DUE TO (c) <u>Terminal convulsive state</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>6 mo</u> <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 31, 1955</u> to <u>May 9, 1956</u> , that I last saw the deceased alive on <u>May 9, 1956</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>May 10, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. S. Severel</u>	

MEDICAL CERTIFICATION

TO REGISTER OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077373364

MAY 14 1956

BUREAU V.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

Item 7, Film 198 5-31-56 et

5378

CERTIFICATE OF DEATH

Reg. Dist. No.

05423

245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	c. LENGTH OF STAY IN 1b <u>5 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOME</u>		d. STREET-ADDRESS <u>3805-QUEENS CLIPPEL RD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>O'DEA</u> Last <u>O'DEA</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 4TH, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PATRICK J. O'DEA</u>	
14. MOTHER'S MAIDEN NAME <u>TORIN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>SACRED HEART HOME RECORDS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23, 1956</u> to <u>May 26, 1956</u> , that I last saw the deceased alive on <u>May 25, 1956</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>35 New York Ave NW</u> DATE SIGNED <u>May 26, 1956</u>			
ACTUAL SIGNATURE <u>Page & Williams</u> M.D.		PHYSICIAN'S NAME (Type) <u>P. S. WILLIAMS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Washington DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831 G Ave NW</u>		24a. REC'D BY REGISTRAR <u>Ms. Jas. Severe</u> DATE <u>May 26, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Ms. Jas. Severe</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. 5

MAY 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Foote</u>		d. LENGTH OF STAY IN 1b <u>14 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Foote</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7067 Oxon Hill Road</u>				d. STREET ADDRESS <u>7067 Oxon Hill Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Leroy Padgett</u>				4. DATE OF DEATH Month Day Year <u>May 11 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1, 1897</u>	9. AGE (In years last birthday) <u>58</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lishear Padgett</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Pickersell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-24-2283</u>		17. INFORMANT Address <u>Frances Padgett, same as dec'd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 14-56</u>				22b. DATE THEREOF <u>May 14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Barnabas</u>	
22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros 1661-9th St</u>			
24a. REC'D BY REGISTRAR DATE <u>May 11-56</u>				24b. REGISTRAR'S SIGNATURE <u>Edna F. Sullivan</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only to be used for the purpose of writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 17 1956
BUREAU V. S.

NAME OF DECEASED [Faint handwritten text]		SEX [Faint handwritten text]		AGE [Faint handwritten text]	
DATE OF DEATH [Faint handwritten text]		TIME OF DEATH [Faint handwritten text]		PLACE OF DEATH [Faint handwritten text]	
OCCASION OF DEATH [Faint handwritten text]		CAUSE OF DEATH [Faint handwritten text]		MANNER OF DEATH [Faint handwritten text]	
SIGNATURE OF MEDICAL EXAMINER [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]	
CITY OF DEATH [Faint handwritten text]		COUNTY OF DEATH [Faint handwritten text]		STATE OF DEATH [Faint handwritten text]	

CERTIFICATE OF DEATH

Reg. Dist. No.

231

5412

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5403 Newton Street				d. STREET ADDRESS 5403 Newton Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First STELLA Middle GERTHA Last PASQUALLE				4. DATE OF DEATH Month May Day 18th , Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21st, 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Unicoi, Tenn.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Taylor				14. MOTHER'S MAIDEN NAME Nacy J. Scoggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or date of service) None		17. INFORMANT James S. Killingbeck		Address 5403 Newton St. Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-Sclerotic Coronary Heart Disease DUE TO (c) 4 years INTERVAL BETWEEN ONSET AND DEATH 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-Sclerotic Hypertension & Chronic Thrombosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 5510 Madison Street				20g. (County) East Riverdale, Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Oct. 20, 1953 , to 5-18-1956 , that I last saw the deceased alive on 5-18-1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Albert Roth M.D. 5510 Madison Street DATE SIGNED 5/19/56 PHYSICIAN'S NAME (Type) Albert Roth East Riverdale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/56		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colman Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE 5/20/56		24b. REGISTRAR'S SIGNATURE Amanda Loomney	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

See District

Name of Deceased		Sex		Race		Date of Birth		Place of Birth	
John Doe		Male		White		1900		New York	
Usual Residence		Place of Death		Cause of Death		Manner of Death		Occupation	
123 Main St.		123 Main St.		Heart Disease		Natural		Teacher	
Date of Death		Time of Death		Physician		Hospital		Burial Place	
May 20, 1956		10:00 AM		Dr. Smith		St. Mary's		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAY 22 1956

RECEIVED

5454

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH - COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED - STATE D. C. COUNTY -		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Glenn Dale (rural)		LENGTH OF STAY (in this place) 4 mos., & 10 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR Washington 47X-3		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital			STREET ADDRESS (If rural, give location) 2025 Benning Rd., N. E.		
3. NAME OF DECEASED (Type or Print) (First) OLMSTEAD (Middle) H (Last) PERRY		4. DATE OF DEATH (Month) may (Day) 23 (Year) 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated, not legally	8. DATE OF BIRTH 7/31/05	9. AGE last birthday 50 yrs.	10. UNDER 24 HRS. (If under 24 hrs. Months. Days Hours Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Austin Perry			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			14. MOTHER'S MAIDEN NAME Mabel Turner		
16. SOCIAL SECURITY No. 1927-1930 578-42-9355		17. INFORMANT AND ADDRESS Decedent			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
002 X	Immediate cause	(a) <u>Pulmonary Hemorrhage</u>	<u>1 day</u>
	Antecedent cause(s)	(b) _____	
	Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u>	(c) <u>For advanced Pulmonary Tuberculosis</u>	<u>8 years</u>
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
								Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE				INJURY				(STATE)	
HOMICIDE									
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF				While at					
INJURY			m.	Work <input type="checkbox"/> Not While					
				At work <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from 1-13, 1956, to 5-23, 1957, that I last saw the deceased alive on 5-23, 1957, and that death occurred at 4:25 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
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23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>		DATE <i>5/24/56</i>	NAME OF CEMETERY OR CREMATORY <i>M.D.</i>	LOCATION (City, town, or county) <i>St. Louis, Mo.</i>	(State) <i>Mo.</i>
DATE REC'D BY LOCAL REG. <i>5/24/56</i>		REGISTRAR'S SIGNATURE <i>W. W. W.</i>		24. FUNERAL DIRECTOR <i>Mahon & Liley Inc. 4 J. Ave at 28th St. Wash. D.C.</i>	

MARGIN ~~RESERVED~~ FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

JUN 1 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5413

CERTIFICATE OF DEATH

Reg. Dist. No.

0542731

1. PLACE OF DEATH. a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSPITAL</u>		d. STREET ADDRESS <u>9106 Autoville Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MADGIE</u> First <u>MAE</u> Middle <u>PERSINGER</u> Last		4. DATE OF DEATH <u>MAY</u> Month <u>9</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1902</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Birmingham, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Henry R. Persinger, 8220 Foxridge Rd., Pittsburgh, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY, Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>5/9/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/7/56</u> , 19 <u>56</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>7409 Varnum St.</u>		DATE SIGNED <u>5/9/56</u>	
PHYSICIAN'S NAME (Type) <u>Landoner Hills, Md</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>5/11/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Unnada Journey</u>			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		Jan 10, 1956		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Last Medical Advice		Date of Last Medical Examination		Date of Last Medical Examination		Date of Last Medical Examination		Date of Last Medical Examination		Date of Last Medical Examination		Date of Last Medical Examination		Date of Last Medical Examination	
Teacher		Married		None		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955		Jan 1, 1955	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 10, 1956		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.		Jan 10, 1956		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.		Jan 10, 1956		10:00 AM	

BUREAU V. E.

MAY 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5379

CERTIFICATE OF DEATH

05428

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges <i>County</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bells Nursing Home			d. STREET ADDRESS 4011 Tennyson Rd		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Mary Frances Peters			4. DATE OF DEATH Month Day Year May 19, 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1956		9. AGE (In years last birthday) yrs. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Edward Louis Peters			14. MOTHER'S MAIDEN NAME Augustas Hauptly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Edward Peters University Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary heart disease</i> 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary heart disease</i> DUE TO (c) <i>myocardial infarction</i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>5/1</i> 1956, to <i>5/19</i> 1956 that I last saw the deceased alive on <i>5/19</i> 1956, and that death occurred at <i>6:50</i> P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>J. Christensen</i> M.D.			DATE SIGNED <i>5/20/56</i>		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.			24a. REC'D BY REGISTRAR DATE May 23 1956		
			24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe</i>		

2097363XV8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05429

Reg. Dist. No.

240

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Melwood</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Melwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodyard Road</u>				d. STREET ADDRESS <u>Woodyard Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>May</u> <u>Eloise</u> <u>Proctor</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>26</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>October 16, 1934</u>		9. AGE (In years last birthday) <u>21 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Thompson</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Proctor</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217 36 5538</u>				17. INFORMANT Address <u>Mrs. Mary Thompson, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>292.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardosis</u> DUE TO (c) <u>Sickle Cell Anemia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>649X</u> <u>Eight months pregnancy.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>			
22d. LOCATION (City, town, or county) <u>Rosaryville, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>		24a. REG'D BY REGISTRAR DATE <u>9 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>John L. Banner</u>		DATE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a portion of the certificate is necessary, please execute the portion necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 29 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05430

5414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>3306 Shepherd Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>M</u> Last <u>Pryor</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Dec. 1872</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Pennock J. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Harriett East</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-42934</u>	
17. INFORMANT <u>Charles C. Pryor</u> Address <u>3601-Tilden St Brentwood Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>45</u> , to <u>May 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>56</u> , and that death occurred at <u>0130</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. C. Hageage</u>		ADDRESS (Street, city or town, state) <u>Mt. Rainier, Md.</u> DATE SIGNED <u>May 25, 1956</u>	
PHYSICIAN'S NAME (Type) <u>C. C. HAGEAGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nelley's Funeral Home</u> ADDRESS <u>3200 Ph. Dr. Annapolis</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 8 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>H. H. Shwick</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		10 DAYS		JUN 5, 1956		BALTIMORE		MD		USA		USA	
EDUCATION		SCHOOLING		RELIGION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
HIGH SCHOOL		8 YEARS		METHODIST		MARRIED		JAN 15, 1910		BALTIMORE		MD		USA		USA	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		1875		1885		BALTIMORE		BALTIMORE		MD	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S RACE	
																W	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY	
LABORER		HOUSEWIFE		1875		1885		BALTIMORE		BALTIMORE		MD		MD		USA	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S RACE	
																W	

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RECEIVED
JUN 8 1956
BUREAU

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 1PM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5456

CERTIFICATE OF DEATH

05401

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George's		MARYLAND		STATE Maryland		COUNTY Pr. Geo's Co.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Suitland		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Suitland, Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 300- Swann Road S. E.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ANN R. PURDY				4. DATE OF DEATH (Month) (Day) (Year) May 11th. 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 22- 1871	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin E. Randall				14. MOTHER'S MAIDEN NAME Nancy Brooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mary I. Kubar - 300- Suitland Road SE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442 X IMMEDIATE CAUSE (A) Acute Congestive Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH 3 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardiovascular Renal disease				5 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Osteoarthritis				20 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Natural Causes			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 17, 19 47, to May 11, 19 56, that I last saw the deceased alive on May 11, 19 56, and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
SIGNATURE Paula F. Collins				ADDRESS (Street, city, town, state) M.D. Washington 28 SE		DATE SIGNED May 11 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 11 1956		NAME OF CEMETERY OR CREMATORY Mt Calvary		LOCATION (City, town, or county) (State) Forestville, Md.	
24. REC'D BY REGISTRAR DATE May 11-1956		REGISTRAR'S SIGNATURE Paula F. Collins		25. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS 1661- Good Hope Rd SE	

1991-1992

1. *Journal of the American Medical Association*, 1997; 277: 1025-1030.

10/11/19

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BUREAU V.

MAY 17 1956

RECEIVED
MAY 12 1964

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5457

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			
c. LENGTH OF STAY IN 1b 14 Years				d. STREET ADDRESS 3010 Parkway Ter. Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3010 Parkway Ter. Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZA BETH M. QUINN				4. DATE OF DEATH Month May Day 9th Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1869	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Kent, Ohio		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Whelan		14. MOTHER'S MAIDEN NAME Kehoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Gertrude Malligan Suitland Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS (c) GENERALIZED ARTERIOSCLER.						INTERVAL BETWEEN ONSET AND DEATH 2 HR 2 YR 5 YR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 5. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN , 19 52 , to 5-9 , 19 56 , that I last saw the deceased alive on 5-7 , 19 56 , and that death occurred at 8:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank S. Pellegrini M.D.				ADDRESS (Street, city or town, state) 3409 AAA Ave DC			
DATE SIGNED 5-9-56				PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/10/56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross	
22d. LOCATION (City, town, or county) (State) Buffalo, N.Y.				24a. REC'D BY REGISTRAR DATE 5-14-56			
24b. REGISTRAR'S SIGNATURE Carrie Campbell				24c. REGISTRAR'S SIGNATURE WASH 20 DC			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Jan 15, 1956		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Death Certificate		Last Burial Certificate		Last Cremation Certificate		Last Interment Certificate	
Teacher		Married		High School		Catholic		White		White		None		Jan 1, 1956		Jan 1, 1956		Jan 1, 1956		Jan 1, 1956		Jan 1, 1956		Jan 1, 1956		Jan 1, 1956	
Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Jan 15, 1956		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe		Jan 15, 1956		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe	

BUREAU V. S.

MAY 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5415

CERTIFICATE OF DEATH

05433

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore, 27, Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 10 day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last William H. Raubach			4. DATE OF DEATH Month Day Year May 22 19 56		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 7, 1905		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Rileigh Clothes		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert G. Raubach			
14. MOTHER'S MAIDEN NAME Sadie F.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Mrs. Esther Raubach Elkridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolism DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5-12-56					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 5-12 , 19 56 , to 5-22 , 19 56 , that I last saw the deceased alive on 5-22 , 19 56 , and that death occurred at 0200 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) George Hager M.D. 3712-38th DATE SIGNED 5-22-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/56		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge	
22d. LOCATION (City, town, or county) Baltimore		22e. (State) Md.		22f. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR DATE 5/24/56	
24b. REGISTRAR'S SIGNATURE Annanda Downey					

TO BE FILLED BY THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05434

5416

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake, Md.				c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.				d. STREET ADDRESS 3708 Perry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H. Ray				4. DATE OF DEATH May 9 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/9/10	
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressman		11. BIRTHPLACE (State or foreign country) U.S. Governor's Office Wash. D.C.	
13. FATHER'S NAME Arthur C. Ray		14. MOTHER'S MAIDEN NAME Nancy E. Ray Crisp		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-24-3103	
17. INFORMANT Rex L. Ray		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & Pulmonary Edema 545X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Pulmonary Emboli (c) Phlebotrombosis (right leg) following Gastrectomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 4-28-56, 1956, to 5-9-56, 1956, that I last saw the deceased alive on 5-9-56, 1956, and that death occurred at 2-PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE George H. McLain		M.D. 1746 K. St. N.W. - Wash - D.C.		PHYSICIAN'S NAME (Type) G. H. McLain			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Valley's Funeral Home		3200 R.I. Ave		DATE 5/11/56		Hmanda Downey	

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05435

5417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				d. STREET ADDRESS <u>3800 38th Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Chaney</u> Last <u>Reid</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> , Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-04</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Maritime Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Chaney</u>				14. MOTHER'S MAIDEN NAME <u>Julia Beckett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Marshall E. Reid, Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Fracture of Tibia and Fibula</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell on the rear porch of her home.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>10.00</u> o. m. <u>5-1-</u> 19 <u>56</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cottage City, Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>May 13, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>5/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Maranda Dorene</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 15 1956

RECEIVED

5418

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. LENGTH OF STAY in 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George Gen. Hosp.</u>				d. STREET ADDRESS <u>9022-49th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Riddle</u> Last <u>Riddle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>br</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14/74</u>	
10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Riddle</u>				14. MOTHER'S MAIDEN NAME <u>Emma P. Lovelace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-0845A</u>		17. INFORMANT <u>Mrs Margaret Corralie</u> Address <u>9101 Antorville St College Park, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis of neck</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>May 18, 1956</u> to <u>May 30, 1956</u> , that I last saw the deceased alive on <u>May 30, 1956</u> , and that death occurred at <u>3:17 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Goodson</u> M.D.				ADDRESS (Street, city or town, state) <u>1746 K St N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>James R. Goodson</u>				DATE SIGNED <u>May 31 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ammendale</u>		22d. LOCATION (City, town, or county) (State) <u>Ammendale Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaschi Sons</u> ADDRESS <u>Hyattsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>6-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Dourney</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1956

RECEIVED

5458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Andrews Air Force Base</u>		<u>1 wk</u>		OR TOWN <u>District Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1101st USAF Hospital, MATS</u>				STREET ADDRESS (If rural give location) <u>7802 DISTRICT HEIGHTS PARKWAY</u>			
3. NAME OF DECEASED: (First) <u>Ava</u> (Middle) <u>L</u> (Last) <u>Rodriguez</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>11</u> 19 <u>56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Other</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>21 February 1956</u>	9. AGE last birthday yrs. <u>2</u> Months <u>23</u> Days <u></u> Hours <u></u> Min. <u></u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NA</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NA</u>		11. BIRTHPLACE (State or foreign country): <u>Belling AFB, 25, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Mmanuel J. Rodriguez</u>				14. MOTHER'S MAIDEN NAME: <u>Marcella M. Garcia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>7802 Play Terrace Dr. Mmanuel J. Rodriguez, District Hts, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
(Sudden unexpected death of infant)							
IMMEDIATE CAUSE (A) <u>Acute Tracheitis (autopsy findings)</u>							
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to, 19....., that I last saw the deceased alive on, 19....., and that death occurred at <u>0015</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Ronald E. McCollum</u>				ADDRESS <u>M. D. 1401 USAF Hoop AFB/B</u>		DATE SIGNED <u>14 May 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>31 May 56</u>		REGISTRAR'S SIGNATURE <u>Helen M. Michael</u>		24. FUNERAL DIRECTOR <u>Ronald Funeral Home, 816 K St., Wash. D.C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5459

CERTIFICATE OF DEATH

Reg. Dist. No.

05438

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William C. Satterwhite</u>		4. DATE OF DEATH Month Day Year <u>May 29 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11, 1895</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News paper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Distributor</u>	11. BIRTHPLACE (State or foreign country) <u>ALABAMA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Satterwhite</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Heard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>57710 4048</u>		17. INFORMANT <u>Wm. C. Satterwhite</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1-2</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-25</u> , 19 <u>55</u> to <u>May 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.		DATE SIGNED <u>Brandywine MD 5-31-56</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		<u>Brandywine MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-1-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>Blacksburg Rd - Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u>		ADDRESS <u>WALDEN, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Danner</u>	

BUREAU V. S.

1956 4 JUN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05439
231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>Bright Seat Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Schwalier</u> Middle <u></u> Last		4. DATE OF DEATH <u>May</u> Month <u>21</u> Day <u>19</u> Year <u>56</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 3, 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Vegetable Merchant</u>				11. BIRTHPLACE (State or foreign country) <u>Germany Hungary</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Anthony Schwalier</u>								14. MOTHER'S MAIDEN NAME <u>Unknown Elizebeth Graff</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-48-4941</u>				17. INFORMANT <u>A Rhoda Schwalier, Same address</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Cardiac aneurism</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Cardiovascular renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <input checked="" type="checkbox"/> Noturol causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>John T. Maloney</u>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 21, 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/24/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>										ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>5/24/56</u>				24b. REGISTRAR'S SIGNATURE <u>Constance D. Dancy</u>			

MEDICAL CERTIFICATION

TO BE COMPLETED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute it before the body is released, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, Film G198 6-18-56 et

5420

CERTIFICATE OF DEATH

05440

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Scott Last Scott				4. DATE OF DEATH Month May Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 80 ? yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Statistic Card		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident (c) Cerebral arteriosclerosis	
INTERVAL BETWEEN ONSET AND DEATH 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 4-19 , 19 56 , to 5-6 , 19 56 , that I last saw the deceased alive on 5-6 , 19 56 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5510 MADISON ST.		DATE SIGNED 5/7/57	
ACTUAL SIGNATURE Albert Roth		PHYSICIAN'S NAME (Type) Albert Roth		22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-10-56	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery Suitland, Md.		22d. LOCATION (City, town, or county) (State) Suitland, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Robert V. M. [Signature]		ADDRESS 1820-9 St. North D.C.	
24a. REC'D BY REGISTRAR DATE 5/9/56		24b. REGISTRAR'S SIGNATURE Amanda Downey		25. [Signature]		26. [Signature]	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JOHN J. BROWN</p>		<p>DATE OF DEATH MAY 14 1956</p>	
<p>AGE 68</p>		<p>SEX MALE</p>	
<p>RACE WHITE</p>		<p>EDUCATION HIGH SCHOOL</p>	
<p>BIRTH DATE MAY 14 1888</p>		<p>PLACE OF BIRTH BALTIMORE, MARYLAND</p>	
<p>DECEASED'S RESIDENCE 1234 E. BALTIMORE AVE. BALTIMORE, MARYLAND</p>		<p>DECEASED'S OCCUPATION RETIRED</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>MANNER OF DEATH NATURAL</p>	
<p>DATE OF BURIAL MAY 16 1956</p>		<p>PLACE OF BURIAL GREENWICH CEMETERY</p>	
<p>NAME OF FUNERAL HOME GREENWICH FUNERAL HOME</p>		<p>NAME OF MINISTER REV. J. J. BROWN</p>	
<p>NAME OF CLERGYMAN REV. J. J. BROWN</p>		<p>NAME OF CHURCH ST. JAMES CHURCH</p>	
<p>NAME OF PHYSICIAN DR. J. J. BROWN</p>		<p>NAME OF HOSPITAL BALTIMORE HOSPITAL</p>	
<p>NAME OF NURSE MRS. J. J. BROWN</p>		<p>NAME OF ASSISTANT MRS. J. J. BROWN</p>	
<p>NAME OF ATTORNEY J. J. BROWN</p>		<p>NAME OF JUDGE J. J. BROWN</p>	
<p>NAME OF CLERK J. J. BROWN</p>		<p>NAME OF RECORDER J. J. BROWN</p>	

BUREAU Y. S.

MAY 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05441

5421 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGES		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) RIVERDALE		LENGTH OF STAY (in this place) 6 months		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6311 BALTIMORE AVENUE				STREET ADDRESS (If rural give location) 3707 SPRINGDALE AVENUE			
3. NAME OF DECEASED (Type or Print) BERTHA (First) (Middle) (Last)				4. DATE OF DEATH MAY 6 1956 (Month) (Day) (Year)			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	8. DATE OF BIRTH SEPT. 12, 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JULIUS GOLDMAN				14. MOTHER'S MAIDEN NAME ROSE HOFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS DAUGHTER			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153x IMMEDIATE CAUSE (A) UREMIA						4 DAYS	
ANTECEDENT CAUSE(S) DUE TO (B) CARCINOMA OF LIVER & LUNG (METASTATIC)						10 months ?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) CARCINOMA OF SIGMOID COLON						3 years ?	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES MELLITUS						10 mos (?)	
19a. DATE OF OPERATION JULY 1953		19b. MAJOR FINDINGS OF OPERATION CARCINOMA OF SIGMOID COLON (RESECTED)					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JULY 1953, to MAY 6, 1956, that I last saw the deceased alive on May 6, 1956, and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
SIGNATURE <i>David B. Clayman</i>		M.D. 6311 Balto. Ave. Riverdale, Md.		DATE SIGNED 5/6/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-7-56		NAME OF CEMETERY OR CREMATORY Hebrew Friendship		LOCATION (City, town, or county) (State) Balto Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>James Avery</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS 2100 Eutaw Pl	
DATE MAY 8 1956							

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF MINISTER

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF OTHER

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESS

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF MINISTER

20. SIGNATURE OF CLERGYMAN

21. SIGNATURE OF OTHER

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESS

24. SIGNATURE OF PHYSICIAN

25. SIGNATURE OF MINISTER

26. SIGNATURE OF CLERGYMAN

27. SIGNATURE OF OTHER

28. SIGNATURE OF DECEASED

29. SIGNATURE OF WITNESS

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF MINISTER

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF OTHER

34. SIGNATURE OF DECEASED

35. SIGNATURE OF WITNESS

36. SIGNATURE OF PHYSICIAN

37. SIGNATURE OF MINISTER

38. SIGNATURE OF CLERGYMAN

39. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

BUREAU V. S.

MAY 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05442

5422

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier, MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince Georges Gen. Hosp				d. STREET ADDRESS 2804 Upshur St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lydia Sims				4. DATE OF DEATH Month Day Year 5-20 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 9-22-85		9. AGE (In years last birthday) 70 yrs.	
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasury Dept				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Texas	
13. FATHER'S NAME Gustavus Truman Brown				14. MOTHER'S MAIDEN NAME Mary Hervey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 2201				16. SOCIAL SECURITY NO.		17. INFORMANT Address John H. Sims 2804 Upshur St. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X CARCINOMATOSIS DUE TO (b) CARCINOMA of the Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 5 months 3 YEARS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-6, 1956, to 5-20, 1956, that I last saw the deceased alive on 5-20 1956, and that death occurred at 8:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED May 21, 1956							
ACTUAL SIGNATURE Albert Roth M.D.							
PHYSICIAN'S NAME (Type) Albert Roth							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colman Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home Mt. Rainier				ADDRESS 5200 R. 9 Rd.		24a. REC'D BY REGISTRAR DATE 5/22/56	
						24b. REGISTRAR'S SIGNATURE Amanda Dourney	

BUREAU V. S.

MAY 24 1956

RECEIVED

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5423

CERTIFICATE OF DEATH

05443

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>5 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp</u>				d. STREET ADDRESS <u>#7. 5th St Cherry Hill Trailer Pk</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Belle Penelope Smith</u>				4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-96</u>	
				9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>14</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>	
13. FATHER'S NAME <u>James B. Kellus</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Hankam</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155X METASTATIC CARCINOMA</u> DUE TO <u>CARCINOMA OF GALL BLADDER AND BILIARY DUCTS</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>2 YRS</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH 5 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB.</u> 19 <u>56</u> , to <u>MAY 14</u> 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 14</u> 19 <u>56</u> , and that death occurred at <u>9:01 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carl J. Houmann</u>				ADDRESS (Street, city or town, state) <u>Riverdale MD.</u>			
PHYSICIAN'S NAME (Type) <u>CARL J. HOUMANN</u>				DATE SIGNED <u>5-14-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Shutland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>517 11th St. E.</u>		24a. REC'D BY REGISTRAR <u>DATE May 17 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mrs. Jan. Severe</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>May 15, 1956</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Maryland</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		RELIGION <i>Methodist</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Engineer</i>		MILITARY SERVICE <i>None</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>	
FUNDAMENTAL CAUSE <i>Atherosclerosis</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
SIGNATURE OF REGISTRAR <i>John Doe</i>		DATE <i>May 15, 1956</i>	

BUREAU V. S.

MAY 15 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5424 CERTIFICATE OF DEATH

05444

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND CITY OR TOWN <u>Laurel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CHARLES Co.</u> CITY OR TOWN <u>INDIAN HEAD</u> STREET ADDRESS <u>17 POTOMAC AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>JESSIE</u> (First) <u>HEMBROW</u> (Middle) <u>STANFIELD</u> (Last)		4. DATE OF DEATH <u>MAY 3</u> 19 <u>56</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 15, 1873</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>England</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William HEBROW</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unk.) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S ADDRESS <u>DAUGHTER - THEIMA S. ANDREWS</u> <u>17 POTOMAC AVE. INDIAN HEAD - MD.</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332x IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis with Phychosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>With Aphasia</u> (C) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>MANY YEARS</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u> </u>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>	
22. I hereby certify that I attended the deceased from <u>10-18</u> , 19 <u>54</u> , to <u>5-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>56</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Jesse C. Higgins</u>		DATE SIGNED <u>3/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Oakgrove Cemetery</u>		LOCATION (City, town, or county) <u>Americus Ga</u>	
24. REC'D BY REGISTRAR <u>Mollie Breakers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>	
DATE <u>MAY 7 1956</u>		ADDRESS <u>Waldorf Md</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

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BUREAU V. B.

MAY 7 1956

RECEIVED

PHOTOGRAPH

5425

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>				c. LENGTH OF STAY IN 1b <u>37 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ireland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cleo</u> Middle <u>Elizabeth</u> Last <u>Tanner</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-93</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landlady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Charles Jarboe</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Herbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Cleo E. Canterbury-daughter- same address</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DIABETES MELLITUS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u> <u>20 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 16</u> , 19 <u>56</u> , to <u>MAY 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 22</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u> M.D.				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD RIVERDALE MD.</u>			
DATE SIGNED <u>5-23-56</u>							
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Masch Sns</u> ADDRESS <u>4439 Balt Ave 22406 Md.</u>				24a. REC'D BY REGISTRAR <u>May 24, 1956 Mrs. Jas. Bevers</u>		24b. REGISTRAR'S SIGNATURE <u>Refutly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES E. HARRIS		45		M		W		1911		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 MAIN ST. NEW YORK		LABORER		HEART DISEASE		NATURAL		MAY 20 1956		NEW YORK	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE	

BUREAU V. B.

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05446

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Floral Park Road</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u> d. STREET ADDRESS <u>Floral Park Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Herman Washington Taylor</u> First Middle Last				4. DATE OF DEATH <u>May 10 1956</u> Month Day Year													
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 73</u> yrs.		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Taylor</u>						14. MOTHER'S MAIDEN NAME <u>Anna Thorne</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>578-32-4610</u>						17. INFORMANT <u>Etta Pennie</u> Address <u>same address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO (b) <u>cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>James I. Boyd</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 10, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>				22d. LOCATION (City, town, or county) (State) <u>Broodcreek MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>						ADDRESS <u>1661- Good Hope Rd SE Wash. DC</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Edna F. Gillis</u>							

MEDICAL CERTIFICATION

TO BE FILLED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the change, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 17 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5426

CERTIFICATE OF DEATH

05447

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3144 Cherry, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George's Hosp.</u>		d. STREET ADDRESS <u>6408 - 61st Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leonard R.</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1905</u>
9. AGE (In years, lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Western Union</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. G. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Alice Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>161-03-2077</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive failure chronic</u> DUE TO (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u> <u>10 yrs.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>55</u> , to <u>5-16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-16</u> , 19 <u>55</u> , and that death occurred at <u>1:50</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George H. Henge</u> M.D. <u>3712-3802</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5-16-56</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE H. HENGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Vincent</u>		22d. LOCATION (City, town, or county) (State) <u>East Vincent Township, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u> ADDRESS <u>224 R. Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>5/19/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Verneda Bournay</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH													
JAMES H. HARRIS		68		M		W		1887		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE													
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH									
MARRIED		1910		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE									
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH			
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		MYOCARDIAL INFARCTION		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE					
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MAY 22 1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE			

RECEIVED
MAY 22 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5427 CERTIFICATE OF DEATH

06499

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u> MARYLAND		CITY OR TOWN <u>Chesley, Md.</u>		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>		CITY OR TOWN <u>Harry Laneille</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>		STREET ADDRESS (If rural give location)		DATE OF DEATH		DATE OF DEATH	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE	
<u>Baby Girl Thompson</u>		<u>May 22, 1956</u>		<u>F</u>		<u>N</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<u>Single</u>		<u>May 22, 1954</u>		<u>7 yrs.</u>		<u>None</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Ind.</u>		<u>USA</u>		<u>Watson, James</u>		<u>Thompson, Frances</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>No</u>		<u></u>		<u>mother - as above</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
<u>May 22, 1956</u>		<u>Fetal Atelectasis</u>		<u>Yes</u>		<u></u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
<u>No</u>		<u></u>		<u></u>		<u>May 22, 1956</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>May 22, 1956</u> , to <u>May 22, 1956</u> , that I last saw the deceased alive on <u>May 22, 1956</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.		DATE SIGNED	
<u>No</u>		<u></u>		<u>John W. Puckin</u>		<u>May 22, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>May 22, 1956</u>		<u>Prince Georges Gen Hosp</u>		<u>Chesley, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>John W. Puckin</u>		<u>John W. Puckin</u>		<u>John W. Puckin</u>		<u>Chesley, Md</u>	

CERTIFICATE OF DEATH

Form 100-1

1. Name of deceased (Print or write full name)

2. Date of death (Month, day, year)
3. Place of death (City, town, village, or other locality)
4. Cause of death (State immediately and briefly the cause of death)

5. Age (Years, months, days)
6. Sex (Male or Female)
7. Race (White, Negro, Indian, Chinese, Japanese, Hawaiian, or other race)

11. Usual residence (City, town, village, or other locality)

12. Signature of attending physician (Print name and sign)
13. Signature of registrar (Print name and sign)

14. Signature of medical examiner (Print name and sign)

15. Signature of coroner (Print name and sign)

16. Medical certificate (Print name and sign)

17. Signature of funeral director (Print name and sign)

18. Date of burial (Month, day, year)

19. Name of funeral home (Print name)

20. Name of funeral director (Print name)

21. Name of funeral home (Print name)

22. Name of funeral director (Print name)

23. Name of funeral home (Print name)

24. Name of funeral director (Print name)

25. Name of funeral home (Print name)

26. Name of funeral director (Print name)

27. Name of funeral home (Print name)

28. Name of funeral director (Print name)

29. Name of funeral home (Print name)

30. Name of funeral director (Print name)

31. Name of funeral home (Print name)

32. Name of funeral director (Print name)

33. Name of funeral home (Print name)

34. Name of funeral director (Print name)

35. Name of funeral home (Print name)

36. Name of funeral director (Print name)

37. Name of funeral home (Print name)

38. Name of funeral director (Print name)

39. Name of funeral home (Print name)

40. Name of funeral director (Print name)

BUREAU V. S.

MAY 11 1956

RECEIVED

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5428

CERTIFICATE OF DEATH

05448

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>14 HRS.</u>		d. STREET ADDRESS <u>7001 Dartmouth Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>L.</u> Middle <u>Tippett</u> Last		4. DATE OF DEATH Month <u>5</u> / Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1906</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT L. TIPPETT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH RIPKA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>165-10-1987</u>	
17. INFORMANT <u>Statistic Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal Hemorrhage</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bleeding Esophageal varicosities</u> DUE TO (c) <u>Primary Hepatoma of the Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24 hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> to <u>May 2</u> , 19 <u>56</u> that I last saw the deceased alive on <u>May 2</u> , 19 <u>56</u> , and that death occurred at <u>3:55 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Leonard Hays</u> M.D. <u>Hyattsville, Md</u>		<u>5-2-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER</u>		22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins, 3821-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>5/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Leonard Hays</u>			

CERTIFICATE OF DEATH

Form 100-10-10

1. NAME OF DECEASED <i>John A. Smith</i>		2. DATE OF DEATH <i>May 1, 1956</i>	
3. PLACE OF DEATH <i>Home</i>		4. CAUSE OF DEATH <i>Heart Disease</i>	
5. SEX <i>Male</i>		6. AGE <i>65</i>	
7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>	
9. PLACE OF BIRTH <i>Chicago, Ill.</i>		10. DATE OF BIRTH <i>May 1, 1891</i>	
11. SIGNATURE OF DECEASED <i>John A. Smith</i>		12. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
15. SIGNATURE OF DECEASED <i>John A. Smith</i>		16. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
21. SIGNATURE OF DECEASED <i>John A. Smith</i>		22. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
27. SIGNATURE OF DECEASED <i>John A. Smith</i>		28. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
33. SIGNATURE OF DECEASED <i>John A. Smith</i>		34. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
39. SIGNATURE OF DECEASED <i>John A. Smith</i>		40. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
45. SIGNATURE OF DECEASED <i>John A. Smith</i>		46. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
51. SIGNATURE OF DECEASED <i>John A. Smith</i>		52. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
57. SIGNATURE OF DECEASED <i>John A. Smith</i>		58. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
63. SIGNATURE OF DECEASED <i>John A. Smith</i>		64. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
69. SIGNATURE OF DECEASED <i>John A. Smith</i>		70. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
75. SIGNATURE OF DECEASED <i>John A. Smith</i>		76. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
81. SIGNATURE OF DECEASED <i>John A. Smith</i>		82. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
87. SIGNATURE OF DECEASED <i>John A. Smith</i>		88. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
93. SIGNATURE OF DECEASED <i>John A. Smith</i>		94. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
99. SIGNATURE OF DECEASED <i>John A. Smith</i>		100. SIGNATURE OF WITNESSES <i>John A. Smith</i>	

BUREAU V. 1

MAY 7 1956

RECEIVED

Reg. Dist. No. 245

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

MAY 15 1956

RECEIVED

5461

CERTIFICATE OF DEATH

Reg. Dist. No.

743

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High Bridge Road				d. STREET ADDRESS 2500 Wisconsin Ave., N.W.			
3. NAME OF DECEASED (Type or print) First Alice Middle B Last Welch				4. DATE OF DEATH Month May Day 1 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1870	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 2 Days 12 Hours 12 Min.		IF UNDER 24 HRS. Months 2 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -Office Work- Acacia				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James Bright				14. MOTHER'S MAIDEN NAME Mollie Hutchinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-2232		17. INFORMANT Mrs. Welch's diary		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastasis DUE TO (b) Cancer Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 months approx. 12 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar 10 , 19 56 , to 5/1 , 19 56 , that I last saw the deceased alive on 5/1 , 19 56 , and that death occurred at 2:40 M, from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) H. James Kurek				ADDRESS (Street, city or town, state) RFD Bowie Md			
DATE SIGNED 5/1/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/3/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St., N.W. Washington, D.C.		24. REG'D BY REGISTRAR MAY 3 1956	
				24a. REGISTRAR'S SIGNATURE Mrs. John Youngling			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		Jan 20, 1955		10:30 AM	
Occupation		Manner of Death		Physician's Signature		Signature of Registrar	
Teacher		Natural		J. H. Smith		M. J. Doe	
Usual Residence		Place of Death		Hospital or Institution		Name of Hospital or Institution	
123 Main St.		Home		St. Mary's Hospital		St. Mary's Hospital	
Married		Single		Widow		Divorced	
Married		Single		Widow		Divorced	

BUREAU V. S.

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5380

CERTIFICATE OF DEATH

05451
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b <u>15 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>				d. STREET ADDRESS <u>5503 44th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>MINERVA</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 56</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1862</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Nichols</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Annie E. Bergmann, HYATTS., MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		
			20f. (City or town) <u> </u>		(County) <u> </u>		
21. I certify that I attended the deceased from <u>7-14-52</u> 19 <u> </u> , to <u>5-2-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5-1-56</u> , 19 <u> </u> , and that death occurred at <u>4:30 A</u> M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>John P. Clum M.D.</u>							
PHYSICIAN'S NAME (Type) <u>JOHN P. CLUM, M.D.</u> <u>6110 43rd Ave., Hyatts., Md. 5/3/56.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR <u>May 21 1956</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5430

CERTIFICATE OF DEATH

05452

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo. Cty.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Lanham Hills, MD</u>	
c. LENGTH OF STAY IN <u>3 days</u>		d. STREET ADDRESS <u>4908-78th Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Agnes</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-06</u>
9. AGE (In years last birthday) <u>49 yrs.</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>20</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugo Edwards Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>	
17. INFORMANT <u>William B. Williams</u>		Address <u>W Lanham Hills MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Cardiac Arrest</u> DUE TO (b) <u>Mitral Stenosis & Premature Ventricular Contractions</u> DUE TO (c) <u>Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 seconds</u> <u>2 yrs</u> <u>P</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5-17</u> , 19 <u>56</u> , to <u>5-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>1:05</u> P.M. from the causes and on the date stated above.		
ADDRESS (Street, city or town, state) <u>3503 Perry St. Mt. Rainier Md</u>		DATE SIGNED <u>5-20-56</u>
ACTUAL SIGNATURE <u>Waldo B. Moyers</u>		
PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>
22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Guack's son</u>		24a. REC'D BY REGISTRAR <u>5/23/56</u>
ADDRESS <u>4439 Balt Ave 4th floor, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Lounsbury</u>

CERTIFICATE OF DEATH

BUREAU V. 1

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film 197 5-23-56 et

5462

CERTIFICATE OF DEATH

Reg. Dist. No.

05453

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE M.D. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORAL HILLS, M.D.	
c. LENGTH OF STAY IN 1b 5 years		d. STREET ADDRESS 1601-52nd Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH WILLIAMS		4. DATE OF DEATH Month Day Year MAY - 15th 1956	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY-11-1865
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MORRISTOWN, NEW JER.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GORDON ALEXANDER		14. MOTHER'S MAIDEN NAME CATHERINE GURLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Address 1601-52nd Ave. CORAL HILLS, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from April 30, 1956 to May 15, 1956 , that I last saw the deceased alive on May 15, 1956 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE J. H. Thibadeau		ADDRESS (Street, city or town, state) 3112-4th Ave S.E. Wash. D.C.	
DATE SIGNED 5-15-56		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 5-18-56		22c. NAME OF CEMETERY OR CREMATORY HOLYROOD CEME	
22d. LOCATION (City, town, or county) (State) MORRISTOWN, N.J.		23. FUNERAL DIRECTOR'S SIGNATURE WALSH FUN. HOME 741-11th St. S.E. WASH DC	
24a. REC'D BY REGISTRAR MAY 18 1956		24b. REGISTRAR'S SIGNATURE H. H. Thibadeau	

MEDICAL CERTIFICATION

TO HEALTH OFFICER ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death.

MAY 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5431

CERTIFICATE OF DEATH

05454

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>hanham</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp</u>				d. STREET ADDRESS <u>6927 Riverdale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RACHEL E. WILLIAMS</u>				4. DATE OF DEATH <u>May 16 1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-01</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob R Huffman</u>				14. MOTHER'S MAIDEN NAME <u>Mattha Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wm H. Williams sr</u> Address <u>Landon Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinome of Maxillary Sinus</u> <u>160X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 + yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>MAY 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Lear</u>		ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville</u>		DATE SIGNED <u>5-16-56</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>5/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>Maranda Downey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES R. ...		MAY 20 1950	
AGE		SEX	
... years		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTH DATE		BIRTH PLACE	
...		...	
MARRIED		OCCUPATION	
Yes		...	
EDUCATION		CAUSE OF DEATH	
High School		...	
PREVIOUS ILLNESS		PLACE OF DEATH	
...		Home	
DATE OF INTERMENT		PLACE OF INTERMENT	
...		...	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
...		...	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
...		...	

BUREAU V. S.

MAY 20 1950

RECEIVED

5463

05455

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>Farmmont Hgts</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmmont Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmmont Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>710-62nd Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Winfield</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Warrenton Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Lacey</u>		14. MOTHER'S MAIDEN NAME <u>Martha White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Maude Sherwood</u>		Address <u>710 62nd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>53</u> , to <u>May 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Roult</u>		ADDRESS (Street, city or town, state) <u>330-61st St. NE</u>	
PHYSICIAN'S NAME (Type) <u>John W. Roult</u>		DATE SIGNED <u>5/7/56</u>	
22a. CEMETERY OR CREMATORY REMOVAL (Specify) <u>5-11-56</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Washington</u>		ADDRESS <u>467 N. St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. PLACE OF BIRTH		12. DATE OF BIRTH	
13. PLACE OF DEATH		14. TIME OF DEATH	
15. PLACE OF DEATH		16. TIME OF DEATH	
17. PLACE OF DEATH		18. TIME OF DEATH	
19. PLACE OF DEATH		20. TIME OF DEATH	
21. PLACE OF DEATH		22. TIME OF DEATH	
23. PLACE OF DEATH		24. TIME OF DEATH	
25. PLACE OF DEATH		26. TIME OF DEATH	
27. PLACE OF DEATH		28. TIME OF DEATH	
29. PLACE OF DEATH		30. TIME OF DEATH	
31. PLACE OF DEATH		32. TIME OF DEATH	
33. PLACE OF DEATH		34. TIME OF DEATH	
35. PLACE OF DEATH		36. TIME OF DEATH	
37. PLACE OF DEATH		38. TIME OF DEATH	
39. PLACE OF DEATH		40. TIME OF DEATH	
41. PLACE OF DEATH		42. TIME OF DEATH	
43. PLACE OF DEATH		44. TIME OF DEATH	
45. PLACE OF DEATH		46. TIME OF DEATH	
47. PLACE OF DEATH		48. TIME OF DEATH	
49. PLACE OF DEATH		50. TIME OF DEATH	
51. PLACE OF DEATH		52. TIME OF DEATH	
53. PLACE OF DEATH		54. TIME OF DEATH	
55. PLACE OF DEATH		56. TIME OF DEATH	
57. PLACE OF DEATH		58. TIME OF DEATH	
59. PLACE OF DEATH		60. TIME OF DEATH	
61. PLACE OF DEATH		62. TIME OF DEATH	
63. PLACE OF DEATH		64. TIME OF DEATH	
65. PLACE OF DEATH		66. TIME OF DEATH	
67. PLACE OF DEATH		68. TIME OF DEATH	
69. PLACE OF DEATH		70. TIME OF DEATH	
71. PLACE OF DEATH		72. TIME OF DEATH	
73. PLACE OF DEATH		74. TIME OF DEATH	
75. PLACE OF DEATH		76. TIME OF DEATH	
77. PLACE OF DEATH		78. TIME OF DEATH	
79. PLACE OF DEATH		80. TIME OF DEATH	
81. PLACE OF DEATH		82. TIME OF DEATH	
83. PLACE OF DEATH		84. TIME OF DEATH	
85. PLACE OF DEATH		86. TIME OF DEATH	
87. PLACE OF DEATH		88. TIME OF DEATH	
89. PLACE OF DEATH		90. TIME OF DEATH	
91. PLACE OF DEATH		92. TIME OF DEATH	
93. PLACE OF DEATH		94. TIME OF DEATH	
95. PLACE OF DEATH		96. TIME OF DEATH	
97. PLACE OF DEATH		98. TIME OF DEATH	
99. PLACE OF DEATH		100. TIME OF DEATH	

BUREAU V. S.

MAY 14 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05456
Item 9, Film G198 5-28-56 et
5432
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4515 39th Place				d. STREET ADDRESS 4515 39th Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle Wood Last				4. DATE OF DEATH Month May 19, 1956 Day Year 19			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1873	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) St. Mary's Co. Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry Wood				14. MOTHER'S MAIDEN NAME Henrietta Cain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Marguerite Wood Piper 4515 39th Place				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days 6 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 23, 1956 to May 19, 1956, that I last saw the deceased alive on May 18, 1956, and that death occurred at 5:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul E. Piper M.D. 7 Logan Circle N.W. Wash. DC 5/19/56 PHYSICIAN'S NAME (Type) PAUL E. PIPER 7 LOGAN CIRCLE N.W. DC							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 5-22-56		22c. NAME OF CEMETERY OR CREMATORY Harmony	
22d. LOCATION (City, town or county) Wash. DC				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart - 30 - H St. N.E.				ADDRESS		24a. REC'D BY REGISTRAR DATE May 23 1956	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severs				24c. REGISTRAR'S SIGNATURE			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05457

5433

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.R.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Ernest</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-189</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Young</u>		14. MOTHER'S MAIDEN NAME <u>Rebekah ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Son</u>	
17. INFORMANT <u>Clinton Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rejection of left lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>subacute pneumonia</u> DUE TO (c) <u>cancer of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>19 days</u> <u>several months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-7</u> , 19 <u>56</u> , to <u>8-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-7</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Rollins</u>		ADDRESS (Street, city or town, state) <u>5070 Madison St, Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>M.R. Rollins</u>		DATE SIGNED <u>5/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 11 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M.R. Rollins</u>		24a. REC'D BY REGISTRAR <u>DATE May 8-56</u>	
ADDRESS <u>4339 Howard DC</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
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